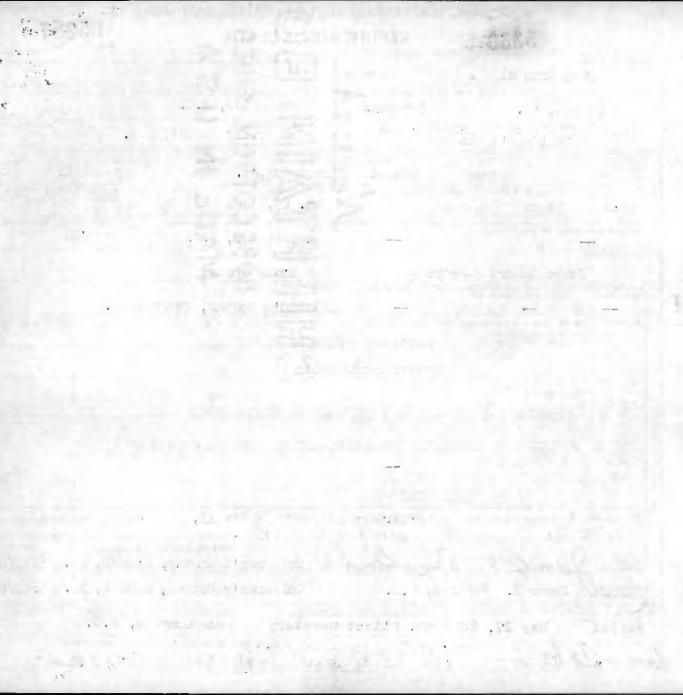
VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5335 CERTIFICATE OF DEATH

| 1. | PLACE OF DEATH | e Arundel | | MARYLAN | | USUAL RESIDENCE (Who of STATE | ere decease | d lived. If institu b. COUNT | | nce befo | re admiss | ian) V |
|---------------|---|---|----------------------------|------------------------------------|-----------------|---|------------------------|-----------------------------------|---------------|----------|------------|-------------------|
| | RURAL ond give no Laure | el, Md. | | 3 months | Ь | Washing to | | | RURAL and | give ne | arest town | 3 |
| | OR INSTITUTION | District to Children's | aini Cent | fgrenool er | | d. STREET ADDRESS 766 Irving | g Stre | et, N.W. | | | | FARM? |
| | NAME OF DECEASED (Type or print) | Fi, Jan | | Middle Edward | Ar | mstrong, Jr. | 4. DATE OF DEATH | Mo | ay | 23 | ay \ | 19 60 |
| 5. | male | 6. COLOR OR RACE | 7. MARE | RIED NEVER MARRIED ED DIVORCED | 8.] E | reb. 25, 1941 | 4 | 9. AGE (In year last birthdoy) | Manths | Days | Hours | R 24 HRS. Min. |
| 10c | USUAL OCCUPATION during most of work | ON (Give kind of work king life, even if retired | done 10b. | KIND OF BUSINESS OR IN | IDUSTR | Washington | | | | IZENO | F WHAT C | OUNTRY? |
| 13. | FATHER'S NAME | | | , - | | 14. MOTHER'S MAIDEN N | IAME | | | | | |
| | Ja | mes Edward | A.me | trong | | Grace Tho | omas | | | | | |
| 15. | WAS DECEASED EVE | | | SOCIAL SECURITY NO. | INF | DRMANT | <u> </u> | Ad | dress | | | |
| YYe | s, no, at snknown) | (If yes, give war or dates of s | ervice) | | Chi | ldren's Cen | ton | Laurel | Md. | | | |
| 1 | IR. CAUSE OF DEA | ATH (Enter only one co | use per lii | ne far (o), (b), and (c).] | OIL | Total 2 Oct | 061 9 | dau o.c. | 1704 | LINT | ERVAL BE | TWEEN |
| | | TH WAS CAUSED BY: | | | | - our laws | | | | | SET AND | |
| | 7/1. | IMMEDIATE CAUSE (o | , | Muscular d | ys U | epny | | | | | | |
| | 1 7.6 | DUE TO | | Mental retar | nda: | rion | | | - | | | |
| | Canditions, if a | mmediate |) | rielical legal | Lua | aton. | - | | | + | | |
| Н | couse (a), stoting | the under- | | | | | | | | | | |
| z | lying cause lost. | J (C | | CONTRIBUTING TO DEATH | BUT NO | OT DELATED TO THE TERMIN | MAI DISEAS | E CONDITION C | IVENI INI DAI | PT 1/e1 | A ZAW GI | ALITOPSY |
| CERTIFICATION | | | | | | | | | IYEN IIY PAI | (1(0) | PERFO | RMED? |
| | 20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES | CRIBE HOW INJURY OCCU | RRED. (| Enter nature of injury in F | Part I ar Poi | rt II af item 18.) | | | | |
| MEDICAL | 20c. TIME OF INJUR Haur o. m. p. m. | Y Manth, Day, Yei 19 | 20d. II While at wor | Not while | PLACI factor | OF INJURY (Hame, farm, y, street, office bldg., etc. | 20f. (Cit | y or lown) | (| County) | | (State) |
| | 21. I certify th | at I attended the | deceas | ed from ebruary | 11 | | y 23. | 160 | ,that I lo | ast say | w the d | eceased |
| | alive an May | 23, | 196 | | | ccurred a5:50A. | | | | | | |
| | 0 | | , | 2 / | , | | ADDRESS (S | treet, city or lowe | , stole) | | | E SIGNED |
| | ACTUAL SIGNATURE | amle 8 | . 0 | 300 lano | MI | Children! | s Cen | ter, Lau | rel, l | 1d. | 5/2. | 3/60 |
| | PHYSICIAN'S NAME (Type) | James E. | Boyla | nd M.D. | | Children | | | | | 5/2. | 3/60 |
| 220 | BURIAL, CREMATIO REMOVAL (Specify) Burial | May 27, | | 22c. NAME OF CEMETER Mt. Olivet | | REMATORY Smetery | | TION (City, lown, | | | (Stote | e) |
| 27 | FUNERAL DIRECTOR | | 73 | a PADDRESS O 14 | ne | 4/10 | D BY REGIS | | SISTRAR'S SI | | | |



05288 **CERTIFICATE OF DEATH** Reg. Dist. No. I director, filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. COUNTY b. COUNTY Mune MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) pinous TICANS Dead d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? remuood Koay YES NO NO 2 4. DATE NAME OF First Middle Month Day Yeor DECEASED DEATH 2 Cu (Type or print) 1960 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years lost builday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days WIDOWED A DIVORCED T 10a. USUAL OCCUPATION [Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 13. BIRTHPLACE (Slote or foreign country) during most of working life, even it retired) 12. CITIZEN OF WHAT COUNTRY? 11.5 - housewel Prelitt ofter 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME physicion mor hours WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. or unknown) | (If yes, give wer or dotter of service) 17. INFORMANT aftending § 2 ·m 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (0) daws DUE TO by Conditions, if ony, which gove rise to immediate **DUE TO** couse (o), stoling the underwara lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 100 19 WAS AUTOPSY PERFORMED? YES NO PA 200. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month. Doy, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while of work of work 21. I certify that I attended the deceased from Velation 1920, that I last saw the deceased 1966, and that death occurred at 2.45 P.M. from the causes and an the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county) (Stote) Cathedra la Cem 23. FUNERAL DIRECTOR'S SIGNATURE DDRESS 7240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS A15 (4) Cithur & Hours 15M 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEASO SO STADENTASO in × HELD AND STREET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5297 CERTIFICATE OF DEATH

05289 Reg. Dist. No.

| | | | | | 0.1 |
|---|---|--|--|---------------------------|---|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel | MARYLAND | 2. USUAL RESIDENCE (WHO STATE Mary. | pere deceased lived. If institution b. COUNTY | | |
| RURAL and give nearest town) | days | | outside corporote limits, write | RURAL and give no | earest fawn) |
| d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION Anne Arundel General Hospital | 1 | d. STREET ADDRESS | D - Arnold | | o. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF First DECEASED (Type or print) Edwin | Middle | Lost BANGERT | 4. DATE Mo OF DEATH Maj | | 00y Yeor 1960 |
| Male White WIDOWED | DIVORCED | 8. DATE OF BIRTH February 14, | 1895 9, AGE (In years lost birthday) | Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND of Juring most of working life, even if relived); Machine Machine Market Machine 1 | ta Groceria | Maryl | and | 12. CITIZEN | OF WHAT COUNTRY |
| WILLIAM H. BANGI | FRT | A KNE | L SCHNE | DER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? [If yes, give wor or dates of service] | SECURITY NO. 17. 1 | HILDA A | L BANGE | FRT | (3) |
| 18. CAUSE OF DEATH [Enter only one couse per line for (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) | o). (b). ond (c).] | y Thimbs | sis | 27.0 | TERVAL BETWEEN NSET AND DEATH |
| Conditions, if ony, which (b) (b) | mony | Cattry | Moins | | |
| couse (o), stoting the under- lying couse lost. | n. arti | ischrosis | ¿ hypul | Unem | ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIL | | | V | IVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? YES NO |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | OW INJURY OCCURRE | D. (Enler noture of injury in I | Part I or Part II of ilem 18.) | | |
| ZOC. TIME OF INJURY Month, Day, Year 20d. INJURY Month, Day, Year 20d. INJURY While N p. m. 19 | OCCURRED 20e. PU for while t work | ACE OF INJURY (Home, form clory, street, office bldg., elc | 20f. (City or lown) | (County | y) (Slate) |
| 21. I certify that I attended the deceased from alive on May 5, 19 60 | | accurred at 3:45A | A.M., from the causes ADDRESS (Street, city or town | and an the de | ate stated above |
| SIGNATURE COMMING (R) | momo | | hgate Aye., | | 5/6/60 |
| | NAME OF CEMETERY O | Annapol R CREMATORY | 15, Md. | or county) | (Stote) |
| Buriel MAY 9-1966 7 23 FUNERAL DIRECTOR'S SIGNATURE | Lemmer | ent Cent | 1 Saltin | COLL SISTRAR'S SIGNATE | me |
| golsen M. Layler uns Co | imapo | - SIPV | | Dathur & H | |

in by the funeral director, and 2 should be filled with may stained by the hospital or attending physician.

DEU. AL DIRECTOR: After this certificate has been signed by the attending physician and completely fill page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages I the registrar prior to burial, crematian, ar removal, and in any event within 72 haurs after death. TO FU VS A15 (4) 15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4,

and a surprise of a first section for the first section of the sec

If any delay is necessary, please exerce functions and director. Page 4 should be

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 0529n Reg. Dist. No. 5298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institutions | Residence before admission) |
|--|---|-----------------------------|
| O. COUNTY A A. CO . MARYLAND | o. STATE M D b. COUNTY | AACO |
| b. CITY OR TOWN (If ausside corporate limits, write RURAL c. LENGTH OF STAY IN 16 and give nearest form) | c. CITY OR TOWN (If outside corporate limits, write RUR) | L and give nearest town) |
| BUNDOOLS - MD DOOF | PARNOID - MARY /a | nd. |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | /d. STREET ADDRESS | e. IS RESIDENCE |
| DUA-ANNE ARUNdel-gen | Dogwood Trailon Park | YES NO |
| 3. NAME OF First Middle | Lost 4. DATE Month | Day Year |
| | BARGE DEATH > | 15 1960 |
| 4.1 | DATE OF BIRTH 9. AGE (In years lost birthday) Most | NDER TYEAR IF UNDER 24 HRS. |
| WIDOWED OLVORCED 3 | -Sune 1908 31 mi | Min. |
| 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRI during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | . CITIZEN OF WHAT COUNTRY |
| Machinist U.S. Civil Service | el Baltimore, Mo. | U15.A. |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| Charles Barge | Viola H. Bowers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. IN | FORMANT Y/ - F- ICHI 40 Addust el. | mor Ale- |
| No mm Unknown Me | -s-Lillian liting Glents | uenie MI |
| 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] | | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: SAMMEDIATE CAUSE (6) Car droe cless | ani | Just Les |
| 4344 DUE TO | | |
| Conditions, if ony, which) (b) | | |
| gave rise to immediate couse | | |
| (o), stoting the underlying out to | | |
| | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN | PART 1(0) 19, WAS AUTOPSY |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | | PERFORMED? |
| 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (En | ter nature of injury in Port 1 or Port 11 of item 18.) | I TO NO A |
| 20b. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTION CONTRIBUT | | |
| 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE | E OF INJURY (Home, form, 120f. (City or town) | (County) (Stote) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE Factor While Not while factor of work of work 19 | ry, street, office bldg., etc.) | , and a |
| 21. I certify that I took charge of the remains described abov | a hald as Autass D. Issaulia D. | |
| | | quiry , and find that |
| death resulted from Natyral causes , Accident , Suic | ide [], Homicide [], Undetermined cause | · 🔲 · |
| ACTUAL ACTUAL | | DATE SIGNED |
| SIGNATURE CAMBULATE | M.D. CHIEF MEDICAL EXAMINER | |
| EXAMINER'S E | ASSISTANT MEDICAL EXAMINER | / 1 |
| NAME (Type) L. LINMARO! | DEPUTY MEDICAL EXAMINER | 5-15-60 |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c, NAME OF CEMETERY OR C | REMATORY 22d. LOCATION (City, town, or cou | nty) (Stote) |
| Burial 18 May 1960 London Park | Cen. Balto, 194 | • |
| 23. FÜNERAL DIRECTOR'S SIGNATURE Gle But nie Mi | 240. REC'D BY REGISTRAR 24b. REGISTRAR | 'S SIGNATURE |
| The hours man alex | DATE MAY 1 9 '60 Child | ur & Health |

with the second of the second

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may retained by the haspital or ottending physician. O FULL AL DIRECTOR: After this certificate has been signed by the ottending physician and completely fit in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 7 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 haurs ofter death.

TO FU

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5299

CERTIFICATE OF DEATH

05291

| | | | | | | | | Keg. Di | ST. 140. | | |
|--|--|-------------------|-------------------------|---|--|------------------------|--|------------|------------|--------------|-------------------------|
| 1. PLACE OF DEATH a. COUNTY | nne Arunde] | | MARYLAND | NI . | USUAL RESIDENCE (WI o. STATE Marylan | | lived. If institution b. COUNTY | | ce before | | _ |
| | f outside corporate limi parest town} | The second second | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lawn) Gambrills | | | | | | | |
| d. NAME OF HOSPIT OR INSTITUTION Anne Aru: | At (If not in hospitol, g ndel Genera | ive street o | oddress) | 1 | d. STREET ADDRESS | | | | •. | IS RESI | DENCE FARM? NO [] |
| 3. NAME OF DECEASED (Type or print) | Bessi | 51 | Middle Ann | Bar | ımgardner | 4. DATE OF DEATH | Moni Ma | | Doy 28 | | reor 19 60 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARR | IED NEVER MARRIED | | Teb. 2. 189 | 7 | 9. AGE (In years lost birthday) | IF UNDER | I YEAR II | | |
| puting most of worl | ON (Give kind of work king life, even if relired e wife | done 10b. | own home | | 11. BIRTHPLACE (Stole | | | | U.S. | WHAT | COUNTRY |
| 13. FATHER'S NAME | | | | 14 | MOTHER'S MAIDEN | NAME | | | | | |
| Lafaye | tte Hounshe | 11 | | | Mary H | ounshe | 11 | | | | |
| 15. WAS DECEASED EVE (Yes, no, or unknown) NONO | R IN U. S. ARMED FOR I'll yes, give wer or dates of s NON® | | none | He | mant Spital rec | ords | Addr | #3S | | | |
| Conditions, if o gove rise to i cause (o), stating lying couse lost. Part 11. OT: | mmediate DUE TO | | enerolerofre of | O.C. | RELATED TO THE TERM | INAL DISEASI | E CONDITION GIV | EN IN PAR | T 1(o) 19. | WAS A PERFOR | AUTOPSY |
| | AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC | CRIBE HOW INJURY OCCUR | RED. (E | iter nature of injury in | Port I or Part | I If of item 18.) | | | | , NO 🗍 |
| 20c. TIME OF INJUR Hour o. m. p. m. | Y Month, Day, Ye | While of work | Nat while | PLACE (factory, | OF INJURY (Home, form street, office bldg., etc. | n, 20f. (⊂ity | or town) | (< | County) | | (Stote) |
| 21. I certify the alive on WACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | at I attended the New 28 Lis Co H3 John Hed | 126 | | th ac | urred at | M, from | 19(M) n the causes a seet, city or town, | nd an t | | state | |
| 220. BURIAL, CREMATIO REMOVAL (Specify) | May 31, 1 | 960_ | Millerest Co | | | Anna | | rvla | | (State | •) |
| 23. FUNERAL DIRECTOR | Fundant Ha | 11 | ADDRESS | | 24a. REC' | D BY REGIST | | TRAK'S SIG | | | |

4.123 4 7 3 ALC: NO COLUMN TRANSPORT OF THE PARTY O 1 the state of the s or a solution + + + + (F - 2 1 (F +)) · . the state of the s

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND 5300CERTIFICATE OF DEATH director, PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b county Anne Arundel Anne Arundel MARYLAND Marvland 0 b. CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) RURAL and give nearest town) Annapolis Annapolis d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE OR INSTITUT ON ON A FARM? Anne Arundel General Hospital 104 Old Crossing Land YES NO.K Middle 4. DATE Manth Day Year DECEASED OF DEATH 19 60 Louise BEADLE May (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH 9 AGE (In years last birthday) Months White Female March 5. 1915 WIDOWED IT DIVORCED | yrs death certificate be executed 12 CITIZEN OF WHAT COUNTRY? 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired) SCHOOLS U.S. FACHER Pennsylvania 14. MOTHER'S MAIDEN NAME 17 INFORMANT SOCIAL SECURITY NO. aftending 1B. CAUSE OF DEATH [Enter only one couse per line for 10), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which (b) agve rise to immediate **DUE TO** cause (a), stating the underlying couse last PAIT IS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART IS WAS AUTOPSY PERFORMED? YES NO KIK 20o. ACCIDENT WAS UNDERLYING FT 20b. DESCRIBE MOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month. 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, | 20f. (City or town) Year (State) factory, street, affice bldg., etc.) Haur a.m. While Nat while of work at wark 21 I certify that (I) (this haspital) attended the deceased from March 1960 to May 30, 1960 that (1) (we) last .__19_60, and that death accurred at 9: M, from the causes and on the date stated above saw the deceased alive an May DIRECTOR: 22a SIGNATO ATTENDING MED DIRECTOR STAFF M.D 22c PHYSICIAN'S 22d ADDRESS NAME (Type) Stuart M. Christhilf Franklin St. Annapolis CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) (Stote) 25a REC'D BY REGISTRAR 25h REGISTRAR'S SIGNATURE Orthur & House



MEDICAL EXAMINER'S CERTIFICATE OF DEATH crepation Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institutions Residence before admission); COUNTY b. COUNTY and MARYLAND burial, b. RITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 1b c. CITY OR JOWN (If outside corporate/limity, write RURAL and give nearest town) OR INSTITUTION (If not in hospital, give street address) Id. STREET ADDRESS e. IS RESIDENCE ON A FARM? S YES NO NAME OF Middle DATE Day Year DECEASED (Type or print) 2 DEATH 196x 6. COLOR OR RACE 7. MARRIED NEVER MARRIED P. AGE (In yedre IFUNDER TYEAR IF UNDER 24 HRS. Months WIDOWED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 2 64 after 2, on Denter 13. FATHER'S MANIE may 14. MOTHERIS MAIDEN NAME Pages Page 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (If yes, give wor or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERPAL BETWEEN ONCET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove rise to immediate couse **DUE TO** (a), stoling the underlying couse fost. Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINALDISEASE CONDITION GIVEN IN PART 1(o) 19, WAS AUTOPSY PERFORMED? 20g. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) writing the w hief Medical I OR: Page 3 sh factory, street, office bldg., etc.) Not while p. m. of work of work 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection K. Inquiry to the Chief ! death resulted frame Natural causes Accident . Suicide . Homicide ... Undetermined cause ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER P **EXAMINER'S** NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or founty) REMOVAL (Specify) Urla 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5302 **CERTIFICATE OF DEATH** Reg. Dist. No. al director. 3 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) COUNTY b. COUNTY lin MARYLAND funeral CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1h c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give neapest town) placks H. NAME OF HOSPATAL (If not in hospital, give street oddress d STREET ADDRESS e. IS RESIDENCE OR INSTITUTION YES NO puo NAME OF First Middle 4. DATE DECEASED OF DEATH (Type or print) 19 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Jast big hday) Months Days DIVORCED [WIDOWED I 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 19. FATHER'S NAME 14 MOTHER'S MAIDEN NAME physician hours WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address aftending within INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Congestive Heart Failure yrs. DUE TO á Hypertensive Cardio Vascular Disease Gr. IV Conditions, if any, which gove rise to immediate **DUE TO** couse (a), stating the under-Generalized Arteriosclerosis lying couse lost. PART IL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO T 20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20c TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20d. INJURY OCCURRED (County) (State) factory, street, affice blda, etc.) o. m While Not while at work of work 19.60 to 19.60 that I last saw the deceased 21. I certify that I attended the deceased fram. , and that death accurred at 8:15 P.M. from the causes and an the date stated above. alive an DIRECTOR: ADDRESS (Street, city or town, stole) DATE SIGNED ACTUAL SIGNATURE Calvert St., Annapolis, Md. PHYSICIAN'S NAME (Type) Johnson. Theodore H. 220 BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY LOCATION (City. EMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24. REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPIZAL OR ATTENDING PHYSICIAN: The law requires that the deamay inclined by the haspital ar attending physician.

TO FUNKAL DIRECTOR: After this certificate has been signed by the attenpage 3 shauld be detached for use as the burial-transit permit. Then plet the registrar prior to burial, crematian, or remaval, and in any event with

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| Loge 4 | directar, | led with | |
| ain certificate be executed within 24 haurs after death. Page 4 | iding physician and campletely fill on by the funeral director, | assertements carbon papers. Pages 1 and 2 should be filled with | |
| 4 haurs | n by | l and 2 | • |
| within 2 | stely fills | Pages | |
| xeculed | d cample | papers. | a see la |
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| certifical | ng physici | e report | A A STATE OF THE PARTY OF THE P |
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5336 **CERTIFICATE OF DEATH**

| 1 | PLACE OF DEATH 6. COUNTY | ne Ar ndel | | MARI | rland . | 2. USUAL RESID | | ere deceased | b cour | | | | ion) |
|---------------|---|---|------------------|---------------------------|----------------|--|-----------------------------|------------------------|------------------------------|-----------|-------------|---------|--------------------------|
| | b. CITY OR TOWN (IF RURAL and give ne Deale | outside corporate fimi arest town) | ts, write | c. LENGTH OF STAY | IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Y Deale | | | | | | | |
| | OR INSTITUTION | AL (If not in hospital, g | ive street | address) | ,,,,,, | d. STREET A | DDRESS | | | | | | IDENCE FARM? NO XX |
| 3. | NAME OF DECEASED (Type or print) | | REVE | Middle | E | Brown | | 4. DATE OF DEATH | M | Worth 2 Y | Day / 9 | 2 | Yeor 19 60 |
| | sex 'emale | 6. COLOR OR RACE White | 7. MARR | DIVORCE | | B. DATE OF BIRTH | | 94 | 9 AGE (In ye last birthdo | y Month | ER TYEAR | IF UND | R 24 HRS Min |
| 10 | during most of working HOUSE | N (Give kind of work on his even if retired) WITE | done 10b. | kind of Business o | OR INDU | | ACE (Stote o | | untry) | 12. | CITIZEN OI | | COUNTRY? |
| 13 | FATHER'S NAME | | | | | 14. MOTHER'S | MAIDEN N | AME | | | | | |
| | Lu | m Rodgers | | | | Mars | garet | Whitt | ington | | | | |
| 15. | WAS DECEASED EVER | | | SOCIAL SECURITY NO |), 17. F | NFORMANT | | | | Address | | | |
| Ĺ | n• | f yet. give war or dates of so NO | arvice) | none | Mi | r. Milfre | ed W. | Brown | Husb | na- s | are a | .S # | 2 |
| | | mediale (| a | ore for (a), (b), and (c) | vy ote | Throw-Cora | npes | 11 | redse | | INTE | My h | TWEEN DEATH |
| CERTIFICATION | 20a. ACCIDENT WAS | ER SIGNIFICANT CON | | ONTRIBUTING TO DE | | | | | | | ART 1(a) 19 | PERFO | AUTOPSY RMED? NO 1 |
| | (IF EITHER, NOTIFY | CAUSE OF DEATH AEDICAL EXAMINER) | | | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJURY Hour a. m. p. m. | Month, Doy, Yes | While of work | NJURY OCCURRED Not while | 20e PL/ foo | ACE OF INJURY (tory, street, office | lome, farm, bldg., etc.] | 20f. (City | or tawn) | | (County) | | (State) |
| | ACTUAL SIGNATURE | at I attended the 19 May. R.B. SASSE | , 19 <u>6</u> | , _ | death | occurred at. N.D. 7 | 11 77 pp~ | M, fram | the cause eet, city of to | s and an | | e state | |
| 22 | BURIAL, CREMATION | , 226. DATE THEREO | F | 22c NAME OF CEM | ETERY O | | | | ION (City, low | | v) | (Sto) | el |
| | BREMOVAL (Specify) | May 23,19 | 960 | Mt Zion M | | | | Mt Zi | | rylan | | Į | -, |
| 23. | FUNERAL DIRECTOR'S | SIGNATURE | - | ADDRESS | | | | BY REGISTE | | GISTRAR'S | SIGNATURI | E | |
| | Hopping Fr | uneral Home | e A | nnapolis. | Md. | | DATE MA | Y 2 3 '6 | 0 | allua. | 04 | | |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 CERTIFICATE OF DEATH 5303 Rea. Dist. No 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution Residence-targre admission) o. COUNTY COUNTY MARYLAND death. b. CITY OR TOWN (If outside carporate limits, write Bro c. LENGTH OF STAY IN 16 g CITY OR TOWN (It/potside corporate limits, write RURAL and give searest town) RURAL and give negrest town). should d. NAME OF HOSPITAL (If not in hospital, give street address) STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO 3. NAME OF First 4. DATE Middle Lost Month Year Day DECEASED (Type or print) DEATH within 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours DIVORCED | WIDOWED IX 100 DSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 13. **EIRTHPLACE** (State or foreign country) CITIZEN_OF WHAT COUNTRY! during roost of working life, even if retired) 13. FATHER'S NAME 14 MOTHER'S MAIDEM NAME IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (s), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** permit. Conditions, if any, which gove rise to immediate **DUE TO** couse (a), stating the underoug lying couse lost. **burial-transit** CATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO Z 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, 20d. INJURY OCCURRED Year (County) (Stole) factory, street, office bldg., etc.) Hour a. p. While Not white of work at work p. m. 21. I certify that I attended the deceased from 19.6. C. that I last saw the deceased alive on and that death occurred at PM, from the causes and on the date stated above. ADDRESS (Street, city or towndstate) DATE SIGNED ACTUAL PHYSICIAN'S MUSONI NAME (Type) BURIAL CREMATION. 226. DATE THEREOF 229-NAME OF CEMETERY OR CREMATORY 22d. LOCATION (C'ty Town, or county) (State REMOVAL (Specify) O 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24g. REC'D BY REGISTRAR 24h, REGISTRAR'S SIGNATURE VS A15 (4) 15M 9/55 DATEMAY 2.6 a thun & thouse



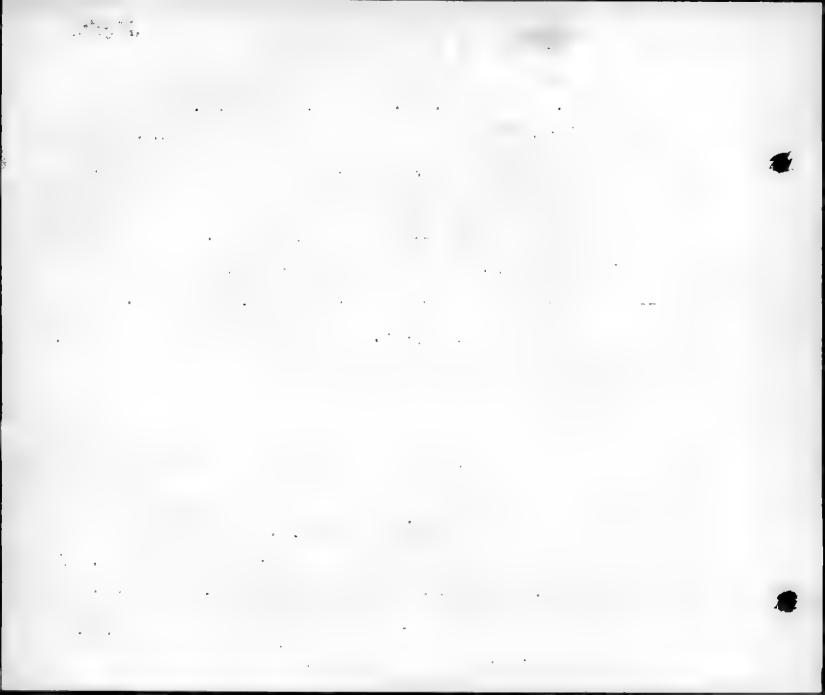
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 75337 **CERTIFICATE OF DEATH** Rea. Dist. No. director PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) n. COUNTY filed **L. COLINTY** MARYLAND Anne Arundel funeral b. CITY OR TOWN (If outside carporate limits, write C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give realest town 1 vrah moa pinous Washington, D. C. d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITADIS Stir 1001 Training School ON A FARM? 1119 Allison Street N.W. Children's Center YES NO NAME OF Middle 4. DATE Year DECEASED 19 60 Aletha Mav fille Joyce Brown DEATH (Type or print) 6. COLOR OR RACE 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED X B. DATE OF BIRTH iost birthday). Months female Negro WIDOWED | DIVORCED 100. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY [1] BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Washington, D.C. USA puo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Viola Rumsey Walter James Brown physicia IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address Children's Center, Laurel, Md. attending p 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY Hydrocephalus 22 mo. IMMEDIATE CAUSE (o' DUE TO Meningomyelocele Canditions, if any, which gned gove rise to immediate DUE TO cause (a), stating the underficate has been sight lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES IX NO attending 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Day, Year 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not while of work of work 21. I certify that I attended the deceased from Jan. 15. 19.59, to May 1, 1960, that I last saw the deceased and that death accurred alt: 30a.M. from the causes and an the date stated above L OR ATTEND ADDRESS (Street, city or lown, stote) 5/4/60 Children's Center, Laurel, Md. should PHYSICIAN'S Children's Center, Laurel, Md. 5/4/60 Hames E. Boyland, M.D. NAME (Type) 22c. NAME OF CEMETERY OF CREMATORY School 22d LOCATION (City town, or county) 220. BURIAL, CREMATION (State) emetary District

24g, REC'D BY REGISTRAR

24b REGISTRAR'S SIGNATURE

arthur S. Kraus

P P Ω Ω VS A15 (4) 15M 9/5B





| 1 | 1 | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 |
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| S ba | X | | 5304MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05299. |
| pleose e 4 should crematic | W. | | a. COUNTY ANNE ARUNDE / MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If Institutions, Residence before admission) o. STATE M. J. COUNTY ANNE ARUNDE |
| Page buright | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANARON (S C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| s nece sctar. iar to | 1 1 | 1 | d. NAME OF HOSPITAL ORANSTITUTION (If not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS d. STREET ADDRESS |
| di pi | | 1 | 3. NAME OF First Middle Last 4. DATE Month Day Year |
| une di ye. | | | Deceased of Print Middle Hast A. BATE Month Day Year OF OF OF Type or print) William H Buddey DO PAYE / 7 1960 |
| h. If on the formed for the real formed for th | | | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH WIDOWED DIVORCED 6-20-92 9. AGE (In years 1 FUNDER 1YEAR IF UNDER 24 HRS. host bighter) WIDOWED DOOR Hours Min. |
| nd 3 to nd 3 to retair 3 2 wit | | | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY! |
| 1, 2, o | | 1 | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME |
| Pages 1 19e 5 n | 1 | - | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address Address |
| ive P. | 1 | 1 | (1 on, no. or ughnown) (1 yes, pigfror or pares of service) None WIFE THOMPSON ALE. |
| ed will 18. G n PM3. | | | 16. CAUSE OF DEATH [Enter only one cause per tine for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH ONSET AND DEATH |
| them th forr | | | 1344 DUE TO |
| d be ocil in ng wil | ь | | Conditions, if any, which go gove rise to immediate cause DUE TO |
| shoul n per s alor | | | couse last. (c) |
| ifficote ding" i s Office sed os | 1 | , | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| his cerl d 'pen aminer' | | | 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part) or Port of item 18.) CAUSE OF DEATH. |
| INER: The worldicol Exe | | | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 120f. (City or town) (County) (State) Hour a. m. While Not while of work of work to the p. m. 19 of work to the p. m. 19 |
| XAM iting f Med F Page | | | 21. I certify that I took charge of the remains described above, held an Autapsy, Inspection, Inquiry, and find that |
| te, wir | | | death resulted from: Natural causes, Accident, Suicide, Hamicide, Undetermined cause |
| MED! rtifica to the | | | SIGNATURE AND VINTAGE M.D. CHIEF MEDICAL EXAMINER DATE SIGNED |
| VERAL Sed | DVOT: | | EXAMINER'S E/MER LINHARDT DEPUTY MEDICAL EXAMINER 5/7/1960 |
| fort Control | 20 20 | | 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, Jown, or county) (Stole) 184124 May 1960 Mendows dee Mem - PK Howay 1 6-, M. (1) |
| VS. A15ME(5 | , , (i | | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE |
| 5M 9/55 | | Į | To le digleton Elen Burni PM DATEMAY 16'60 Clother & them |



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| olh. | | arol di | be file | / |
| 10 MOSPIZAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 | | TO FUND AT DIRECTOR: After this certificate has been signed by the attending physician and campletely filled by the funeral director. | bluor | 40 |
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| 24 ho | A | | 0 | |
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| uted w | | mplet. | pers. | the registrar priar to burial, cromation, ar remaval, and in any event within 72 haurs after death, |
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| ath ce | | nding | edse n | hin 72 |
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| ATTE | by 1h | CTO | e detc | <u>p</u> |
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VS A15 (4) 15M 10/57 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5339 CERTIFICATE OF DEATH

| 1, | PLACE OF DEATH | Arundel | | MARYL | AND | 2. USUAL RESI | DENCE (W | here deceased | d lived If institut b. COUNT | | nce befor | e admiss | ion) |
|--|---|--|---------------|---------------------------------|---------|--|---------------------------|------------------------|--|-------------------------------|------------|-----------|--------------------------|
| | b. CITY OR TOWN (| f outside corporate limi | ls, write | c. LENGTH OF STAY I | N 16 | c. CITY OR | TOWN (If o | outside corpo | rote limits, write | RURAL and | give nea | rest town | 1) |
| | RURAL and give no | reT | | 14 year | S | Washington, D.C. 47\(\lambda\)- | | | | | | | |
| L | OR INSTITUTION | District. Children's | ra'ini Cen | HgwSchool ter | | d. STREET A | | reet S | .Е. | | | | IDENCE FARM? NO [X |
| 3. | NAME OF DECEASED (Type or print) | | essa | Middle | | Butle | | 4. DATE OF DEATH | | oth Iay | 31 | | Yeor 19 60 |
| | sex female | colored | WIDOWE | | | 8. DATE OF BIRT | 34 | | 9. AGE (In years lost birthdoy) 26 yrs | | Days Days | Hours | R 24 HPS Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Wilson N.C. | | | | | | | | | 12. CI | USA | | COUNTRY? | |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S | MAIDEN N | NAME | | | | | |
| | | unknown | | | |] | Marie | Butle | r | | | | |
| 1S. | | R IN U. S. ARMED FOR | | SOCIAL SECURITY NO | 17. 16 | IFORMANT | | | Adı | iress | | | |
| _ | | | | uno emp | Ch | ildren's | s Cen | ter, L | aurel, M | $\operatorname{Id}_{\bullet}$ | | | |
| | 18. CAUSE OF DEA | TH [Enter only one co | use per lin | e for (a), (b), and (c).] | | | | | | | INTE | RVAL BE | TWEEN |
| | | TH WAS CAUSED BY: | | Hypostatic | מס כ | emonia | | | | | ONS | day | DEATH 78 |
| | 35 | DUE TO | | | | 43120 2 6 04 04 | | | | | 15 | | |
| | Conditions, if o | | | Mental ret | tard | lation | | | | | 37. | | |
| | gove rise to in cause (o), stating | mmediate (| | D 13 | | | | | | | | | |
| | lying couse lost. | (c) | | Epilepsy | | | | | | | | | |
| CERTIFICATION | PART II OTH | IER SIGNIFICANT CON | DITIONS C | ONTRIBUTING TO DEAT | TH BUT | NOT RELATED TO | THE TERMI | INAL DISEASE | E CONDITION GI | VEN IN PAI | RT 1(o) 19 | PERFO | AUTOPSY RMED? |
| | 20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY | S UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER | 20b. DESC | RIBE HOW INJURY OC | CURRED |). (Enter nature o | f injury in l | Port I or Port | I II of item 18.} | , | | | 6 |
| MEDICAL | 20c. TIME OF INJUR Hour o.m. p. m. | Y Month, Day, Yea | While | UURY OCCURRED Not while of work | Oe. PLA | CE OF INJURY ! lory, street, affice | Home, form bldg., etc. | 20f. [City | or lown) | ſ | County) | | (State) |
| | 21. I certify th | at I attended the | decease | ed from Octo | ber | 1954 | to Ma | ay 31. | 1060 | that I | last so | ur sha | docessed |
| | alive on May | 31, | . 19 6 | O, and that a | | | | | | | | | |
| | | | _, '~ | , and mark | Jeann | accorred de | | | reet, city or town | | ne dar | | ed abave. NTE SIGNED |
| | ACTUAL SIGNATURE | mayant | W. | mola | ^ | Л.D | | | | | | | |
| | | Margaret W | | a, M.D. | | Ch | | | nter, La | | Md. | | |
| 220 | BURIAL, CREMATIO | N, 226. DATE THEREO | | 22c. NAME OF CEMET | ERY OR | CREMATORY | | 22d LOCAT | ION (City, town, | or county) | | (Stote | =} |
| _ | Burlal | June 3, | 1960 | District | Ing | School | | Ia | urel, 1 | aryla | ind | | |
| 23. | FUNERAL DIRECTOR | SIGNATURE | _ | ADDRESS | - | | 24a. REC'I | D BY REGISTI | | STRAR'S SI | | | |
| L) | John ! | Melsh | > 0 | Isstaury. | D | 1,5, | DATE JI | N 6 'I | 60 0 | inthur a | P. Fire | 1.4 | |



OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ely fille and by the funeral director, Pages 1 and 2 should be filled with O HOS IN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 may be fained by the haspital or attending physician. O FUNITY DIRECTOR: After this certificate has been signed by the attending physician and completely fills page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death.

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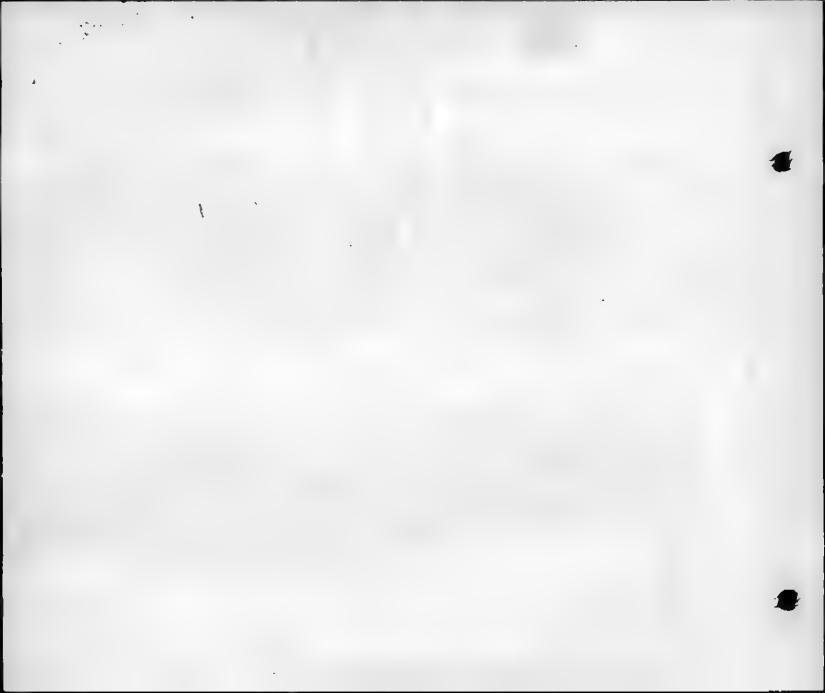
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05301

5340 **CERTIFICATE OF DEATH**

| | | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where | e deceased lived. If institution, Res | idence before admission) |
|----|---------------|--|---------------------------|---|---|---------------------------------------|
| | | COUNTY AA | MARYLAND | o. STATE | b. COUNTY | A |
| | | b. CITY OR TOWN (If outside corporate limits, write | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If our | hde corporate limits, write RURAL a | nd give nearest Iown) |
| | L | RURAL and give regrest town) | 21/2 mm | × | Marson | |
| | \vdash | d. NAME OF HOSPITAL (If not in hospital, give street of | oddress) | Jd. STREET ADDRESS / | | e. IS RESIDENCE |
| | | OR INSTITUTION 409 Name | cy | | | YES NO |
| | | NAME OF First | Middle | Lost 4 | . DATE Month | Doy Year |
| | | (Type or print) Lewis Ra | relocph | Carey | OF Mary Mary | 14 1960 |
| | 5. 5 | 6. COLOR OR RACE 7. MARR | IED 🖾 NEVER MARRIED 🔲 | B DATE OF BIRTH | 9. AGE (In year) IF UN Jost birthdoy) Mont | DER 1 YEAR IF UNDER 24 HRS |
| | | //RCE W. WIDOWE | | June 15 7. | 8 31-11 | hs Doys Hours Min. |
| | 10a | . USUAL OCCUPATION (Give kind of work done 10b during most of working life, even if retired) | KIND OF BUSINESS OR INDU | STRY 11. BIRTHPLACE (Slote or | foreign country) 12. | CITIZEN OF WHAT COUNTRY? |
| j. | 1 | ales Collecton & | nstallinent | (Groomat | the Unit | |
| | 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAM | ME 1 | |
| | | Iseal D. Carec | 1 | auley. | Jamell | |
| | 15. | WAS DECEASED EVER IN U. S. ARMED FORCES? 16 | SOCIAL SECURITY NO 17. I | NFORMANT | Address | |
| | | NO 12 | 27.22-8616 | - Della 1 | . Cases - | Janei |
| | | 18. CAUSE OF DEATH [Enter only one couse per lin | e for (a), (b), and (c)] | | | INTERVAL BETWEEN |
| | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | -do-Vas | Callon Nac | 22701. | ONSET AND DEATH |
| | | DUE TO | | 0.00// | | 1 |
| | | Conditions if any which 3 | | | | |
| | | gove rise to immediate | | | | |
| | | couse (a), stating the under- | | | | |
| | z | PART II. OTHER SIGNIFICANT CONDITIONS C | ONTRIBUTING TO DEATH BUT | NOT PELATED TO THE TERMINA | II DISSACE COMBITIONI CIVEN IN | BART 16-1 10 MEAC AUTODON |
| | \TIO | The office statement committee | CHAIR OF THE BEATT COL | NOT KEDATED TO THE TEXAMINA | ACDISEASE CONDITION GIVEN IN | PERFORMED? |
| 5 | FIC | 20a. ACCIDENT WAS UNDERLYING [] 20b, DESC | DIRE HOW INHIBY OCCUPATI | D. (Enter noture of injury in Por | A Los Book II of How 18 1 | YES NO Z |
| | CERTIFICATION | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | AND HOW HOME WOURKE | b. (ciner noise of injury in For | s s or Fort II of them to j | |
| | CAL | | JURY OCCURRED 20e PL | ACE OF INJURY (Home, form, | 20f. (City or town) | (County) (State) |
| | MEDICAL | Hour o, m. White p, m. 19 of work | Not while to | tory, street, office bldg., etc.) | | (|
| | ~ | 21. I certify that I attended the decease | | 1059 in 5/ | 12/60 10 that | 1 last saw the deceased |
| П | | alive an 3/12/60 19 | | accurred at 1013 (A | M, from the causes and or | |
| | | 01170 011202/04020/0402020202020 | dio illa dedili | | ORESS (Street, city or town, stole) | n the date stated above. DATE SIGNED |
| | | ACTUAL OPERAL & | To fe h | La Flan | 2 | 5/12/6 |
| | | SIGNATURE CLUST - A - A | and the | M.D. YYETEGAYEC | LEGIV /IKS | |
| | | PHYSICIAN'S NAME (Type) | | 4 27 48 48 48 48 48 48 48 48 48 48 48 48 48 | | |
| | 220 | BURIAL CREMATION, 22b. DATE THEREOF | 22c. NAME OF CEMETERY O | R CREMATORY 22 | d LOCATION (City lawn, or count | ly) (Stote) |
| | | Bung 16 My 1960 | Glen Haven | | Glen Burnie | Md |
| | 23. | FUNERAL DIRECTOR'S SIGNATURE | ADDRESS . | 24a. REC'D B | BY REGISTRAR 24b. REGISTRAR'S | SIGNATURE |
| | 7 | Ciolad 7 - Drighton GVE | eniaurnie 14 | Z DATE MA | Y 19'60 arch | 1 S. Kinua |
| | | | | | | |



CERTIFICATE OF DEATH

| a. CO | OF DEATH | = ARUNG | 15L | MARY | rLAND . | 2. USUAL RESIDENCE | Where deceased | tived If institution b. COUNTY | n: Residence be | fore admission) |
|-----------------|-------------------------------------|--|-------------------|---|-----------|---------------------------|---------------------|--|--|--|
| b. CIT | Y OR TOWN (If RAL and give nea | outside corporate lu rest town) | mits, write c. | LENGTH OF STAY | IN 1b | c. CITY OR TOWN | (If outside corpor | ate limits, write RU | JRAL and give n | leatest town) |
| | FAIRU | HEW BE | Ach | 1 dA | У | BAL | TIMOR | ? = | | 1114 |
| d. NA OR | ME OF HOSPITA | L (If not in haspital, | 1 | ress) ' | | d. STREET ADDRES | | istia. | v St. | e. IS RESIDENCE ON A FARM? YES NO JA |
| 3 NAME | OF | | First | Middle | | Last | 4. DATE | Mont | h [| Day Year |
| (Type | ASED or print) | LEO |) | Johr | 1 | ARRIGA | OF DEATH | MAN | 1 15 | 1960 |
| . SEX | | 6. COLOR OR RACE | 7. MARRIED | MEVER MARRI | ED 🔲 8 | DATE OF BIRTH | | P. AGE (In years / | | AR IF UNDER 24 HR |
| M | ALE | white | WIDOWED [| DIVORCE | :D 🔲 | NOV. 23, | 1908 | 5-/ yrs | Months Days | Hours Min. |
| a. USU durir | AL OCCUPATION | (Give kind of warling life, even if refire | k dane 10b, KIN | D OF BUSINESS C | OR INDUST | RY 11. BIRTHPLACE (| State or foreign co | untry) | 12. CITIZEN | OF WHAT COUNTRY |
| | ERVICE | _ | Oi | L Bure | NER | MAR | YLANC | | 4. | S. A. |
| . FATH | ER'S NAME | | 7 | | | 14. MOTHER'S MAID | EN NAME | | , | |
| | 6 E | RGE C | ARR | 19AN | | ELIZ. | abeth | The | LEN | |
| | DECEASED EVER | IN U.S. ARMED FC | | CIAL SECURITY NO | | FORMANT | | Addr | | |
| 1 | 00 | NONE | | 7-01-6998 | 8 2.C | LMA CAK | RIGAN | 1909 C | hRISTI | AN ST. |
| 1B. (| CAUSE OF DEAT | H [Enter only one | couse per line fo | or (o), (b), and (c). | 1 | . 0 | | | IN | NTERVAL BETWEEN |
| | PART I. DEAT | H WAS CAUSED BY | (o) (o) | anan | 1/ | arond | 22m | | ~ | AJE, AND DEATH |
| 4 | 120 | DUE T | | unisace | and | Caro | Les -10 | isanla | 40 | |
| Co | nditions, if on | , which } | (b) | | | / | | | • | |
| | ve rise to im se (o), stating tl | mediate (DUE T | | | | | | | | |
| | ig couse lost. | | (c) | | | | | | | |
| 5 | PART II. OTHE | R SIGNIFICANT CO | NDITIONS CON | TRIBUTING TO DE | ATH BUT N | OT RELATED TO THE | ERMINAL DISEASE | CONDITION GIV | EN IN PART 1(0) | 19 WAS AUTOPS! PERFORMED? |
| <u> </u> | | | | | | | | | | YES NO |
| 20a, OR C | ACCIDENT WAS CONTRIBUTING I | UNDERLYING [] CAUSE OF DEATH AEDICAL EXAMINER | 20b. DESCRIB | O YAULNI WOH 38 | CCURRED. | (Enter noture of injur | y in Part 1 or Part | II af stem 18.j | | |
| ــــا ب | TIME OF INJURY | | | RY OCCURRED | 20e PLAC | E OF INJURY (Hame, | form, 20f. (City | or lown) | (County | y) (Stote |
| 4 | Hour o.m. | 19 | While | Not while | Focto | ory, street, office bldg. | ., etc.) | | | |
| | | | | - A | 6 | 1 67 | The state | 15.66 | | |
| | ~ | t lattended th | e deceased | , | 4 | , 19, 10. | P. T | | | aw the decease |
| aliv | e an | <u> </u> | | , and that | death | accurred at | | he causes and met, city or lown, : | | te stated abov |
| ACTL | | ILTK | Ton | - At | | 1716 | ADDRESS (SI) | er, city of lown, | 1 11 | DAIL SIGH |
| SIGN | IATURE | 1 | July | 2005 | M | .D | | | | |
| | SICIAN'S RE (Type) | ALBERT | rSi | agne | TI | | | THE WAS A SECOND | allia illia shiri illia anda silla anda silla shar allia shi | *** |
| | IAL, CREMATION | , 22b. DATE THERE | EOF Z | 2c. NAME OF CEM | ETERY OR | CREMATORY | 22d. LOCAT | ON (City, town, o | r county) | (State) |
| | OVAL (Specify) | 5-19-6 | 60 | NEWC | PATH | EDRAL | BA | LTIMOR | E, A | Yd. |
| 3. FUNE | RAL DIRECTOR'S | SIGNATURE / | YUNGKA. | ADDRESS | 1 | | REC'D BY REGISTI | AR 24b. REGIS | TRAR'S SIGNAT | URE |
| AT A DE | vuais an | miller | | Frederi. | - 4 Ce | we DA | AY 1 8 '60 | Cloth | 1 S. Hours | 4 |

ond 2 should be filed with Pages 1

irs after deoth. Page 4

TO HUSE ALL OR ATTENDING PHYSICIAN: The now requires many the mined by the haspital ar ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and campletely filled page 3 should be detached far use as the burial-transit permit. Then please remove carbon popers. Pages the registrar prior to burial, cremation, ar remayal, and in any event within 72 frouts after death.

VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 5342 CERTIFICATE OF DEATH

05303

|) | | PLACE OF DEATH COUNTY A. A. MARYLANE | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY A A | | | | | | |
|---|----------|---|---|--|--|--|--|--|--|
| | Ŀ | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Round Bay | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Round Bav | | | | | | |
| < | · | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d STREET ADDRESS o. IS RESIDENCE on A FARM? YES \(\) NO \(\) | | | | | | |
| | | NAME OF First Middle DECEASED Type or print) LINWOOD LEAVITT | CARTER DEATH Month Day Year DEATH May 11, 19 60 | | | | | | |
| | S. S | female white widowed to Divorced | B. DATE OF BIRTH P. AGE (In years of lost birthdoy) Nov. 25, 1879 P. AGE (In years of lost birthdoy) Months Doys Hours Min. | | | | | | |
| | 10a. | USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home | DUSTRY 11, BIRTHPLACE (Slote or foreign country) 12. CITIZEN OF WHAT COUNTRY? | | | | | | |
| | 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | | | |
| | | WAS DECEASED EVER IN U. S. ARMED FORCES? Id. SOCIAL SECURITY NO 17. (If yes, give war or dotes of service) 217-03-7285 | Mr. Thomas L. Carter - Round Bay, Md. | | | | | | |
| | | 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o). DUE TO | INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| | | | is to the blue | | | | | | |
| 0 | FICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH E | OUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO C | | | | | | |
| | CERT | 20b. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCUP OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| | MEDICAL | 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. Hour o. m. May 14 19 6 While of work of work | PLACE OF INJURY (Home, form, 20f (City or fown) (County) (State) factory, street, office bldg., etc.) | | | | | | |
| | | 21.1 certify that (I) (this hospital) attended the deceased from saw the deceased alive an MaJ12 1950, and tha | t death accurred at M, from the causes and on the date stated above | | | | | | |
| , | | 220 SIGNATURE KAMILIS & Codd | M.D. ATTENDING MED. STAFF SIGNED | | | | | | |
| 1 | | Physician's NAME (Type) Francis I. Codd M.D. | 22d. ADDRESS Severna Park, Lary L d | | | | | | |
| | | BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERS REMOVAL (Specify) Burial May 17, 1960 Druid Pidgo | | | | | | | |
| | 24. | FUNDRAL DIRECTOR'S SIGNATURE ADDRESS | 250. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE | | | | | | |
| | | | MA | | | | | | |

TO HOW ALD DIRECTOR: After this certificate has been signed by the attending physician.

TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carban pages 1 and 2 shauld be filed with the State Board at Health prior to burial, cremation, ar remayol, and in any eyent, within 72 hours after death.

VR A15 (4) 15M 9/59



ond 2 mould be fited with hours ofter death. Page 4 may be alread by the haspitol ar ottending physicion. O FUNE At DIRECTOR: After this certificate has been signed by the attending physician and campletely fille page 3 should be detoched for use as the buriol-transit permit. Then please remaye carbon papers. Pages the registrar prior ta burial, cremotion, or removal, and in any event within 72 hours after death. ALOR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 TO HOSE TO FUNE

VS A15 (4) 15M T0/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5343 **CERTIFICATE OF DEATH**

| 5343 CERT | IFICATE OF DEATH | O.S. | 5304 |
|--|--|--|---|
| IIVNE /IKUIVIEL | 2. USUAL RESIDENCE (Where o. STATE | deceased lived. If institution Residue. b. COUNTY | ence before admission) A A - |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give-reares) town) | Y IN 16 c. CITY OR TOWN (If outside X 33 × 15 4 c.) | de corparate limits, write RURAL and | d give nearest lown) |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES P NO |
| 3. NAME OF DECEASED (Type or print) ///// Am /// / eve/and | | DATE Month OF DEATH | 8 1960 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARI WIDOWED DIVORCE DIVORCE | RIED 8. DATE OF BIRTH | 9 AGE (In years) IF UNDE | R TYEAR IF UNDER 24 HRS. |
| 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS during most of working life, even if retired) | - 1/11/V/19 /00 | 7 73 yrs. Dreign country) 12 C | ITIZEN OF WHAT COUNTRY |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | nd. | <i>c.</i> > <i>n</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY N (19 year, given wor or dates of service) 2/3 3 8 434/ | O. 17. INFORMANT MAS. Mar. | Address Address | RF2 LAPLY BOUZELE TO |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) ON OTHER | 7 Thompour | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if ony, which gove rise to immediate couse (a), stating the under- | larte CVP Kluen | al_ | 8 yio |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO D | EATH BUT NOT RELATED TO THE TERMINAL | DISEASE CONDITION GIVEN IN PA | RT 1(a) 19 WAS AUTOPSY PERFORMED? YES NO |
| 20a. ACCIDENT WAS UNDERLYING CORESCRIBE HOW INJURY (OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | OCCURRED (Enter noture of injury in Port I | or Port II of ilem 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of work | 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) | Of (City or town) | (County) (Slote) |
| 21. I certify that I attended the deceased fram | Arch . 1948, to 8 / | may 1960, that I | last saw the deceased |
| ACTUAL SIGNATURE SIGNATURE | M.D. Whee Min | RESS (Street, city or town, state) | 8 may 6 |
| PHYSICIAN'S NAME (Type) | | | |
| Busiel 181/60 Trinity | Church Contra | LOCATION (City, lown, or county) | Kery Mid |
| Bussied O Harkerty La | lesville His DATE MAY | 4 = 1 = 1 | S Krush |



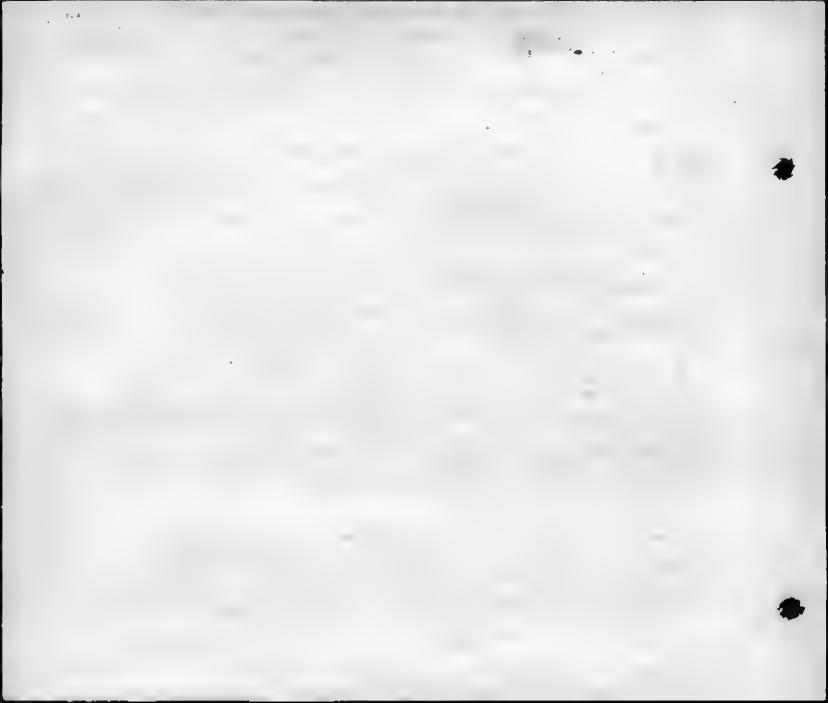
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

| 44 | CERTIFICATE | OF | DEATH |
|----|-------------|----|--------------|
| | | | |

| | 5344 | CERTIFICA | ATE OF DEATH | | Reg. Did | 15305 |
|---------------|--|------------------------|--|------------------------|-------------------------------------|--|
| 1. | PLACE OF DEATH Q Q. | MARYLAND | 2. USUAL RESIDENCE (Whe | | If institutions Residence COUNTY | before admission) |
| 2 | b. GITY OR TOWN (If outside corporate limits, write c. L. RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street oddre OR INSTITUTION) | ENGTH OF STAY IN 16 | SCITY OR TOWN (4 or STREET ADDRESS Urnveld | (P 1 | its, write RURAL and gi | • IS RESIDENCE ON A FARMS |
| L | NAME OF DECEASED (Type or print) SEX 6_COLOR OR RACE 7_MADDIFT 8 | Middle C | Lost Literood K. | 4. DATE OF DEATH | Month MCM (In Mars IV UNDER) | Doy Yeor 1960 YEAR IF UNDER 24 HRS |
| 10 | Male WIDOWED WIDOWED WIDOWED | DIVORCED 🗍 | 3-13-19 | 16 4 | yes. | Days Hours Min. ZEN OF WHAT COUNTRY? |
| L | during most of mothing life, even if retired) FATHER'S NAME FATHER'S NAME | S. NAVY | 14 MOTHER'S MAIDEN N | oma | 7 | S-A |
| 15. (Y | WAS DECEASED EVER IN U. S. ARMED PORCES? 16. SOCI | TAL SECURITY NO. 17 H | SEATR LEANOR | B.C.Hi | 118 tou | #2 |
| | TIB. CAUSE OF DEATH [Enter only one couse per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if any, which gove rise to immediate couse (a), stating line under: Lying cause last. (c) | r (o), (b), and (c)] | and all be | fact. | ×1. | INTERVAL BETWEEN ONSET AND DEATH |
| CERTIFICATION | PANT 11. OTHER SIGNIFICANT CONDITIONS CONT | | | | | 1(0) 19. WAS AUTOPSY PERFORMED? . YES NO S |
| _ | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | D (Enter nature of injury in P | | | |
| MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJUR Hour a. m. 19 White at work | Not while for | ctory, street, office bldg , etc. | 1207. (City or low) | 1) [Ce | ounly) (State) |
| | 21. I certify that I attended the deceased for alive an MANAGER 17 19(LD) | | accurred at 5 | | causes and an th | ost saw the deceased abave, DATE SIGNED |
| | PHYSICIAN'S NAME (Type) | | Clare | ili, M | | |
| 22 | DELINIAL, CREMATION, 226. DATE THEREOF 22. PRINCIPLE (1960) | C. NAME OF CEMETERY OF | Memorial | 22d LOCATION (C | ity, town or county) | (Stole) |
| 23 | FUNERAL DIRECTOR'S SIGNATURE / CURS L | ADDRESS | lis Me 240. REC'E DATEMAY | 0.100 | 246 PEGISTRAR'S SIGI CINHUN S. 1 | |

HAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 2 in by the funeral director, and 2 should be filed with moy rollined by the hospital or ottending physicion.

O FUT ALDINICTOR: After this certificate has been signed by the attending physician and completely fit page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages the registrar prior to burial, cremation, or removal, and in any event within 72 hours often death. TO FU



TO HOSPIAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 >= In by the funeral director, and 2 should be filed with

TO FUR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5305 **CERTIFICATE OF DEATH**

05306

| | Keg, DIS. NO. |
|--|--|
| 1. PLACE OF DEATH 6. COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. STATE 7 / / / / / / / / / / / / / / / / / / |
| b. CITY OR TOWN (If outside carporale limits, write RURAL and give neocest town) Annapolis | c. CITY OR TOWN (If artiside corporate limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | A STREET ADDRESS ON A FARM? YES NO NO |
| 3. NAME OF DECEASED (Type or print) (Type or print) (Type or print) | Cook Death May 7 19 60 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Male Negro WIDOWED DIVORCED | 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Manihs Days Haurs Min. |
| 10s. USUAL OCCUPATION (Give kind of work done during most of morking life, even if retired) | STRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME HEARING CAPLE | 14. MOTHER'S MAIDEN NAME HARRIED CAPE |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.) 1 [Tex. no. of (phanourn)] [If yes, give wer or dated of service) | Informant Care Gert Right - 3 (1022 Car) |
| 18. CAUSE OF DEATH [Enter only one cause per line for (o). (b). and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | Obstruction |
| | and Wound of Second 18 days |
| gave rise to immediate cause (a), stating the under lying cause last. DUE TO (c) A Cut's Supply | wikative appendicities 19 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 200 ACCIDENT WAS UNDERLYING TO DEATH BUT OR CONTRIBUTING TO COURSE OF DEATH OR CONTRIBUTING TO COURSE OF DEATH OR CONTRIBUTING TO COURSE OF DEATH OR CONTRIBUTING TO DEATH BUT 200. DESCRIBE HOW INJURY OCCURRED THE STATE OF THE S | I NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSYL PERFORMED? YES 2 NO |
| | D. (Enter nature of injury in Part I or Part II of item 18.) |
| Oc. TIME OF INJURY Manth, Day, Year 20d, INJURY OCCURRED to Plant Mour o. m. p. m. 19 at work of one of work of the control of t | ACE OF INJURY (Home, farm, 201. (City ar tawn) (County) (State) clary, street, office bldg., etc.) |
| 21. I certify that I attended the deceased from April 1 | 17,. 19 60, to May 7, 19 60, that I last sow the deceased a occurred at 7:054 M. from the causes and on the date stated above. |
| ACTUAL R. L. Reliandon | ADDRESS (Street, city or town, stole) ADDRESS (Street, city or town, stole) ADDRESS (Street, city or town, stole) |
| | St., Annapolis, Md. |
| 134 116 5-11-1/60 BUTALL | OR CREMATORY. 22d LOCATION (City, town, or county)) (State) |
| 23) FUNERAL DIRECTOR'S SIGNATURE | 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE OATEMAY 1 1 '60 Orthur 2. Kraus |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5306 CERTIFICATE OF DEATH with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) n. COUNTY b. COUNTY g MARYLAND Anne Arundel Maryland Anne Arundel ofter death. ero b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest fown) 70 Annapolis RURAL - Annapolis shoul d NAME OF HOSPITAL (If not in hospital, give street address) or institution (Dead on arrival. d. STREET ADDRESS Rt-4. Box-712, Mulberry Hil Anne Arundel General Hospita NAME OF First 4. DATE Middle Lost Month DECEASED Mary COOK (Type or print) Jane DEATH Mav within 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 9. AGE (In years 5. SEX 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdoy) Months Days Female Negro WIDOWED I DIVORCED [7] April 21, 1900 60 popers. yes 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? edyring most of working life, even if retired) U.S. Maryland ond carbon 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME physician remove hours IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO requires that ል ij. ony Conditions, if any, which ! gave rise to immediate **DUE TO** cause (a), stating the underlying cause fast. buriol-transit PAIR II. OTHER SIGNUSICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of item 18) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED (County) factory, street, office bldg., etc.) See Hour o. m. Not while ot work at wark p. m 21. Fcertify, that I attended the deceased from ! 1922 that I last saw the deceased at 2735 and that feath occurred _M, from the causes and on the date stated above. ADDRES (Street, city or town, state) ACTUAL SIGNATURE 110 Clay St. should PHYSICIAN'S NAME [Type] L. Richardson Annapolis. Md. 220. BUR AL, CREMATION, 226 DATE THEREOF 22d LOCATION (Eity, town, or county) 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify 0 240 REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE

IS RESIDENCE ON A FARM?

YES 🗍 NO 🔀

PERFORMED? YES NO

(Stote)

DATE-SIGNED

(State)

MAY MAY

Yeor

19 60



I by the funeral director, I and 2 should be filed with

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5307

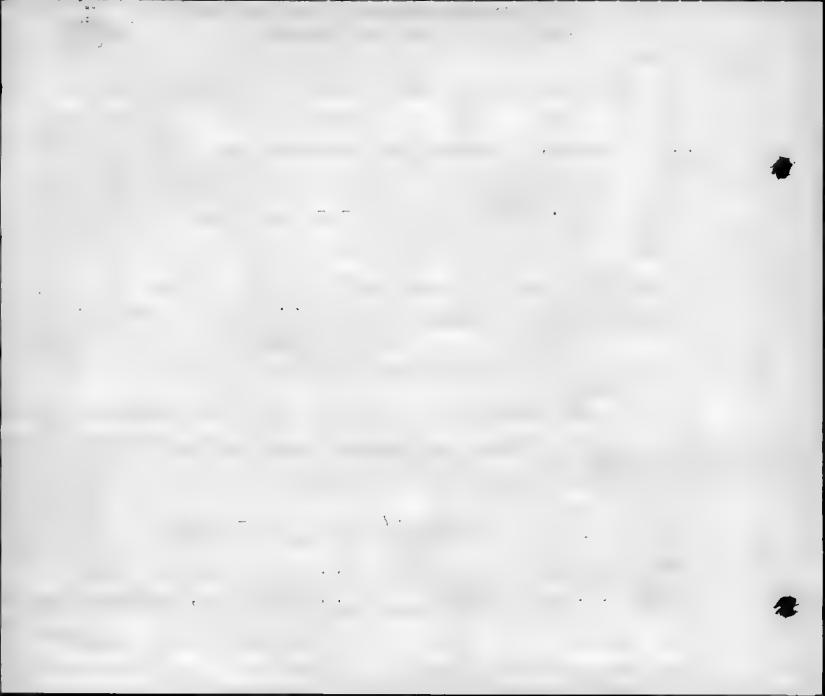
CERTIFICATE OF DEATH

Reg. Dist. No. 308

| | 1. PLACE OF DEATH o. COUNTY | | | | | 2. USUAL RESIDENCE (| Where decease | | nı Residenc | e before | odmiss | ion) |
|---|---|---------------------------------------|----------------|------------------------|------------|--|-----------------|---------------------------------|-------------|----------|----------|-----------|
| | ANNE | ARUNDEL | | MARYL | AND | | TAND | b. COUNTY | ANNE | ARUN | DEL | |
| | b. CITY OR TOWN (If o RURAL and give near | utside corporate limit est town) | s, write c. | LENGTH OF STAY | N 1b | c. CITY OR TOWN (I | If outside corp | orate limits, write RI | JRAL and g | ive near | est town | } |
| | ANNAPOLIS | | | 24 days | | A MERK MA | YO | | | | | |
| | d NAME OF HOSPITAL OR INSTITUTION | (If not in haspital, gi | ve street oddi | ress} | | d. STREET ADDRESS | | | | • | IS RES | FARM? |
| | U.S. NAVAL H | · · · · · · · · · · · · · · · · · · · | | | [TAMD | BISVER | | GIN . | | | YES 🗌 | NO |
| | 3. NAME OF DECEASED | Fire | | Middle | | Lost | 4. DATE | Mon | lih | Day | | feor . |
| | (Type or print) | MARY | | | PREW | · | DEATH | 1.75.7 | [[CILVED ED | 28 | | 9 60 |
| | | | | NEVER MARRIE | | DATE OF BIRTH | OHA | 9. AGE (In years lost birthday) | Months | Days | Hours | Min. |
| | Female 100. USUAL OCCUPATION | 0000 | WIDOWED [| | | 13-11-67 | 8/3 | 86 yrs. | 112 617 | 7501.05 | MALLAT | COUNTRY? |
| | during most of working | life, even if retired) | Z/ | ID OF BUSINESS OF | KINDUŞI | | | countryj | 12. (11 | | | COUNTRY |
| 1 | HOUSENIFE 13. FATHER'S NAME | | 1/47 | me. | | MARYLAN 14. MOTHER'S MAIDEN | | | | USA | | |
| | Carrison STO | TEMAN N | | | | Mary Eli | | TAVIOD | | | | |
| | 15. WAS DECEASED EVER I | | FS2 IA SOC | TIAL SECUPITY NO | 17 IN | FORMANT | zabeth | | en BEV | TOTA | D.2. | AOU |
| | | yes, give wor or dates of se | rvice) | NE . | | GHTER:MRS.V | יויזגדע ז | | | 0, M | | ion, |
| | 18. CAUSE OF DEATH | L Center and one on | | | - | CITITAL STREET | P TETTAT | 014 | 1°LF4_L | | EVAL BE | VAICEA1 |
| | PART I. DEATH | WAS CAUSED BY: | | or folt folt and felt. | | OCARDIAL IN | TPARAPT | OM | | ONSE | T AND | DEATH |
| | LION" | MMEDIATE CAUSE (o) DUE TO | | | 211 | OORIDIAL IN | I ALCOLL | 011 | | | mor | 1011 |
| | Conditions, if ony | makink V | ARTER | IOSCLEROT | TC H | EART DISEAS | 190 1 | | | UNKNOWN | | |
| | gove rise to imm | nediote (OUT TO | | | - | | 743 | | | - 021 | 117401 | 174 |
| | cottse (o), stating the lying couse lost. | under- | | | | | | | | | | |
| | PART II. OTHER | | | ITRIBUTING TO DEA | TH BUT N | NOT RELATED TO THE TER | MINAL DISEAS | SE CONDITION GIV | EN IN PART | 1(0) 19 | . WAS | AUTOPSY |
| | Ē | | | | | | | | | | | RMED? |
| | PART II. OTHER 20a. ACCIDENT WAS OR CONTRIBUTING E OR CONTRIBUTING E | UNDERLYING | 20Ь. DESCRIB | BE HOW INJURY OF | CURRED | (Enter noture of injury i | in Port 1 or Pa | rt II of item 18.) | | | | |
| | | EDICAL EXAMINER) | | | | | | | | | | |
| | 20c. TIME OF INJURY Hour a. m. | Month, Day, Yea | | | 20e. PLA | CE OF INJURY (Home, fo ory, street, office bldg., o | orm, 20f. (Cit | y or town) | (0 | ounly] | | (Stote) |
| | Hour a.m. | 19 | While of work | Not while of work | 100 | ory, sireer, orthor biogr, | eic.j | | | | | |
| | 21. I certify that | I attended the | deceased | from1630_5 | -22 | , 19 <u>_60</u> _, to_0 | 558 5- | 28 . 19.60 | .that 1.1 | ast sa | w the | deceased |
| | alive on 0400 | 5-28 | _ 19_60 | | | occurred at Q55 | | | | | | |
| | -7- | 7 // | | · . | 4 | | ADDRESS (S | Street, city or town, | stote) | | D.A | TE SIGNED |
| | SIGNATURE T | 4. Kennth | MOUSER | An K.A. (So | da N | o U.S. NAV | AL HOS | PITAL AND | NAPOL | IS. | MARY | LAND. |
| | PHYSICIAN'S | | | | | | | | | | | |
| | NAME (Type) R | A. BOTTA | LT MC | USNR | | U.S. NAV | AL HOS | PITAL, AN | NAPOL. | IS. | MARI | IAND_ |
| | 220. BURIAL, CREMATION, —REMOVAL (Specify) | | 22 | 2c. NAME OF CEME | TERY OR | CREMATORY | 22d. LOGA | TION (City, town, o | r county) | | K. (Ston | 1 |
| | "Duricet | may 31 | -1960 1 | Londo | 11 | Tash Cenet | 120 | altenu | te | | 1/4 | |
| | 23 FUNERAL DIRECTOR'S | SIGNATURE/ | Sem | ACORESS | pot | 24a. RE | EC'D BY REGIS | TRAR 245, REGIS | TRAK'S SIG | | | |
| | 110000011, | - cry ovi | | - / | / | DATE | WALD | | | | | |

TO HOSPIAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may the lained by the haspital ar attending physician.

D FUNCAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill page 3 shauld be detached for use as the burial-transit permit. Then please remaye carbon papers. Pages the registrar prior to burial, crematian, ar remayal, and in any event within 72 hours after death. TO FUN VS A15 (4) 15M 9/SS



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| | OU | U | | | | | | AIH | OF DEA | CAI | CEKIII | | | 034 | - 0 | | | | | L |
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| | | _ | ITY | If institu . COUNI Prin | Ь. | ceased | here deceo | _ ` | usual Resider | 11 | MARY | | | | el_ | | E OF DEAT | a. COU | a | 1 |
| | d give | AL and | e RUR | its, write | rate limit | carpor | outside car | WN (If o | c. CITY OR TO | N 16 | OTH OF STAY | e c. LENG | its, writ | parate lim | f autside car agrest tawn) | | | | Ь | |
| (| | | | | | | RS. | rin | Camp St | | days | 8 | | | | 4 | wnsvi | 100 | C | |
| | | | | | | | | RESS | d. STREET ADD | | | et address) | Jive str | haspital, | AL (If not in | HOSPITA | AME OF HE | d. NAA | d | |
| 1 | | | | | oad | a R | town | len | 6185 AT | | | al | ipid | e Ho | e Stat | rille | wnsvi | row | C | |
| 3. | | | Aanth | M | | ATE | 4. DATE | | Last | | Middle | | sl | Fi | | | E OF | NAME DECEAS | . N | š. |
| | | | 5 | | | | DEAT | n | Cotto | | | 2 | llie | Li | | †} | or print) | | | |
| j. 5 | ERIYE | Manths | | E (In year birthday) | 9. AGE | | | | ATE OF BIRTH | D □ B. | NEVER MARRI | ARRIED 🔲 I | 7. M | OR RACE | 6. COLOR | | | SEX | 5. SE | į. |
|] | Day | wonins . | rrs. | | 59 | | | | 1900 | | DIYORCE | MED 🔲 | WIDO | 0. | Negr | | ale | eme | F | |
| 00 | ITIZEN | 12.CI | | | ountry) | KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or fareign country | | | | | | DE KIND O | dane 1 | d af wark | ON (Give kin ing life, eve | CUPATIO | JAL OCCU | . USJA | 0a. | Ć |
| | U | | | | | | | novm | Unkr | | | | , | n ii (eiliec | ing the, eve | | Unkno | | | |
| 3. | | | | | | | NAME | AIDEN N | . MOTHER'S M. | | | | | | | 4ME | ER'S NAM | FATHE | 3. F | 2 |
| | | | | | | | | 10WI | Unkr | - | | | | | | nown | Unkno | U | | |
| 5. | | S | Addres | Ac | | | | | MANT | 17. INFO | SECURITY NO | 16. SOCIAL | | | | | DECEASE | WAS D | 5. V | 1 |
| | | | | | | | rds | leco: | spital I | He | nown | Unk | ervice] | rorodates or: | (If yes, give wor | | nown | | |) |
| Canditions, if any, which gave rise to immediate cause (o), stoting the under-lying cause last. Part II. Other SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART (a) 19 WAS AUTOPSY PERFORMED? | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATION | | | | tem 1B } | t II af rte | r Part | | njury in l | inter nature of 11 | | W INJURY O | | | ING DEATH | S UNDERLYI CAUSE (MEDICAL E) | IBUTING | CONTRIBU | LOR CO | | |
| MEDICAL | (Caun | | | (n) | or town | (City | | | OF INJURY (Ha , street, affice b | | _ علنطست | d. INJURY C | W | | Y Manth, | | Haur a | | MEDICAL | MEDICAL |
| | 60 he do | | ond | 11 ouses o | 5/1 the co | .to | 5.00 to | 4 4 | 5/3 h occurred | | deceosed 60, and | | 5/1 | | et (I) (this | deceos | | saw | | |
| | | | | | STAF | R 🗀 | NED. PIRECTOR [| M DI | ATTENDING PHYS. | м. | | η | Ciro | OK | Herry | and | WILLIAM PHYSICIA | 46 | | |
| | Ma | al, | it | Hosp | te E | Sta | le St | | Crown | M.D. | issman, | | | | - | (Type) | NAME (T) | | | |
| | 2 | ug g | 00 | 25b, REG | ice | un | 23d.100 | - nce | ony | TERY OR | AME OF CEM | 1) | Δ. | TE THERE | 5 | (Specify) | RIAL, CREA MOYAL (Sp LACO) ERAL DIRE | Bu | | - |
| < | -4 S. | | | 230, KE | | | MAY 1 | ATE | IV | Sti | 5-120 | 301 | a. | 4-(| Lines | TiR | Mm.7 | 707 | S | 4 |

moy stained by the hospital or attending physician.

TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed—eith the State Board of Health prior to burial, cremation, or remayal, and in any event, within 72 hours after death H

AL OR ATTENDING MITSICIAM: The law requires that the death certificate be executed within 24 pours after death | Tage 4

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TO HO VR A15 (4) 15M II/59



0531()
Reg. Dist. No.

| \ E | |
|----------|--|
| <i>\</i> | PLACE OF DEATH a. COUNTY a. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institutions: Res dence before odmission) b. COUNTY ATT 1 ATT |
| | b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest lawn) RURAL and give nearest town) Glen Burns Glen Burns A |
| | d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION d. STREET ADDRESS d. STREET ADDRESS or INSTITUTION 4. STREET ADDRESS VES NO D |
| 3 | NAME OF DECRASED (Type or print) Francis Sheridan FATCN 4. DATE Month Day Year (Type or print) Francis Sheridan FATCN DEATH 5 23 1960 |
| | 16. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH Male 16. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH WIDOWED DIVORCED 18. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Haurs Min Wind Haurs Min 18. DATE OF BIRTH 19. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 18. DATE OF BIRTH 18. DATE OF BIRT |
| 1 | Oa. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPIACE (State or foreign country) Making Engineer Beth lehem Stee Lamoing Maine U.S-A. |
| 1 | Frank Eaton [14. MOTHER'S MAIDEN NAME Lanknewn] |
| | 5. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (St. ma. or unknown) (If yes, give wor or date of service) 217 07 2238 Mrs. Hilderiele A. Enton Same As *2 |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Condition, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. |
| 0.00 | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO CONTRIBUTING OF DEATH OF CONTRIBUTING OF DEATH OF CONTRIBUTING OF CONTRIBUTION OF CONTRIBUTI |
| | |
| 1 | 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a. m. p. m. 19 at wark |
| ı | 21. I certify that I attended the deceased from AUG., 1950, to Morch, 1960, that I last saw the deceased alive on Morch, 23, 1960, and that death accurred at 15 1/2M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED |
| | SIGNATURE C 15/1/ach aliase 11/14. M.D. BC4 Craise Hwy 34-5236 |
| | PHYSICIAN'S CAN MAME (Type) CAN MAME (Type) CAN MAME (Type) |
| 2 | 22. BUR AL, CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (State) 13 LUT 14 25 May 1960 13a/to-National Com- 3a/to-Md. |
| 2 | 3. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAN 25 60 ALLEN SIGNATURE MAY 25 60 DATE ALLEN SIGNATURE MAY 25 60 DATE |

ours after deoth. Page 4 ely filled in by the funeral director, Pages 1 and 2 shauld be filed with LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24.5. TO HOST IL OR ATTENDING PHIDICIANS THE NEW CONTROLL OF ALL CANDING PHYSICIAN MAY U. Adding the hospital or attending physician.

TO FUNEKAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 the registrar prior to burial, cremation, or removal, and in any event within 72 haurs offer death. VS A15 (4) 15M 9/58



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AAL DIRECTOR:

TO FUNE

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VS A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

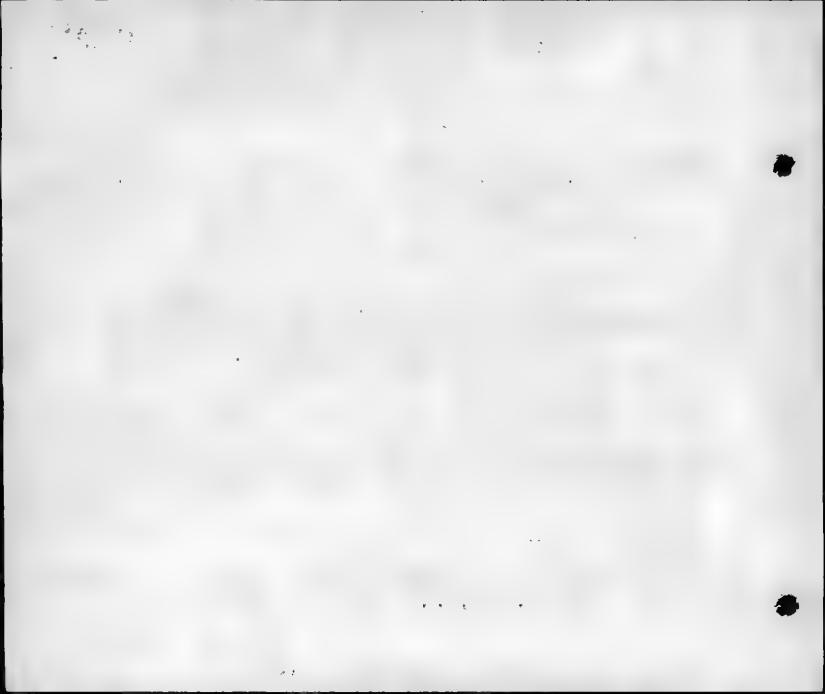


VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5330MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 U5312 Reg. Dist. No.

| 11. | PLACE OF DEATH o. COUNTY Inne Arunde | 2] | | MARYI | LAND | 2. USUAL RES | IDENCE (W | here deceas | ed lived. If | Institut | ion: Resid | ence bel | fore admi | ssion} |
|------------------------------------|---|--|----------------|---------------------------|-------------------|-----------------------------|----------------------------|---------------|---------------------------|--------------|------------|----------|------------------------------------|---------------------|
| 1 | . CITY OR TOWN (II | outside corporate limits, write | RURAL | c. LENGTH OF STAY I | N 1b | | TOWN (IF | outside corp | oorate limits | , write | RURAL and | d give n | earest for | wn) |
| | ond give recomm town) Odenton | | | 2 vears | | X Sa | me | | | | | | | |
| 1 | d. NAME OF HOSPITA | L OR INSTITUTION (| f not in hosp | ital, give street oddress |) | d. STREET ADDRESS e. IS RE: | | | | | | | | ESIDENCE A FARM? |
| E | Baltimore a | and Pine Av | enues | | | Same | | | | | | | 1 | NO [] |
| 3. | NAME OF DECEASED | Fin | ri | Middle | | Los | | 4. DATE OF | | Month | | Day | Y | ear |
| | (Type or print) | Rev. Emar | | | | | | DEATH | May | the | 30th | / | | 9 |
| 5. 3 | SEX | 6. COLOR OR RACE | 1 | NEVER MARRIED | | DATE OF BIRTH | 1 | | 9. AGE (in) last birthda | years lyl | (FUNDER | Days | Hours | ER 24 HRS Min. |
| | М. | W. | WIDOWED | | | | | | 67 | yrs, | | | | |
| 100 | USUAL OCCUPATIOn of working | IN (Give kind of work of life, even if retired) | Jone 10b. KI | ND OF BUSINESS OR II | NDUSTR / | Y 11. BIRTHPL | ACE (Stote | ar foreign ç | ountry) | | 1 | | | COUNTR |
| | Ministe | er | 140- | synothethoch | irch | Shelby, Michigan 1.5.H- | | | | | | | | - |
| 13. | FATHER'S NAME | | | | | | | AME | | | | | | |
| 7.5 | The odore Finck Helen Bush . WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address | | | | | | | | | | | | | |
| | | IN IN U. S. AKMED FO. (If yes, give wor or dates of | service) | OCIAL SECURITY NO. | | | | | | ddress | 1 | | | |
| | No | server | | 1-36-9166 | Mr | s. Rudo | lph M | eyer | daugh | ter |) | | | |
| | | H [Enter only one cau | se per line fi | or (o), (b), ond (c).] | | | | | | | | ONSE | NTERVAL BETWEEN ONSET AND DEATH | |
| | PARI I, DEAI | H WAS CAUSED BY: IMMEDIATE CAUSE (0) | | onary Arter | | | | | | | | | | |
| | DUE TO Arteriosclerotic Heart Disease. | | | | | | | | | | | | | |
| | Canditions, if any, which (b) (b) | | | | | | | | | | | 1_ | | |
| (o), stoting the underlying DUE TO | | | | | | | | | | | | | | |
| 1 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY | | | | | | | | | | | | | |
| CERTIFICATION | PART II. OTH | ER SIGNIFICANT CON | DILIONS COL | NTRIBUTING TO DEATH | EUTN | OT RELATED TO | THE TERMI | NAL DISEAS | ECONDITIO | N GIV | EN IN PAR | | PERFO YES X | NO |
| | 20a. EXTERNAL CAU PRIMARY ☐ or CON CAUSE OF DEATH. | SE WAS | b. DESCRIBE | HOW INJURY OCCUR | RED. (En | iter nature of in | ijury in Part | I or Part II | of item 18.) | | | | | |
| MEDICAL | 20c. TIME OF INJUR Hour o. m. p. m. | Y Month, Day, Yea | While | k of while | e. PLAC factor | E OF INJURY (I | Home, form bldg., etc.) | 20f. (City | or lawn) | | (Co | unty) | | (Stote) |
| | 21. I certify th | at I took chorge | of the re | emoins described | abov | e, held on | Autopsy | La li | rspection | TK. | Inqui | y [2] | , and | find the |
| | death resulted | from: Natural | causes K |], Accident [], | Suic | ide 🔲, H | lomicide | , U | ndetermin | ned c | ause [| j | | |
| | ACTUAL SIGNATURE | O hail | is S | litter | 4 | M.D. CHIEF N | AEDICAL EX | AMINER 🖺 | | | | | DATE S | |
| | EVALUAÇÃO | | | 1 | | ASSISTA | NT MEDICA | AL EXAMINE | R 😭 | | | | 5/31 | /60 |
| | EXAMINER'S NAME (Type) | Charles | S. Pet | ty. M.D. | | DEPUTY | MEDICAL E | XAMINER [| 3 | | | | | |
| 220 | REMOVAL (Specify) | 2 June1 | 1 | Glen Hove | | CREMATORY | | | TION (City, | | | | (State | |
| 23. | FUNERAL DIRECTOR | SIGNATURE | | ADDRESS | | 0.1 | | BY REGIST | RAR 24b. | REGIS | TRAR'S SIG | | | |
| 1 | uchand . | Singleton | فر | Hen Beren | ركد | M. | DATE | UN 6 | '60 | - 0 | lilling. | 8. 14 | AUA | |

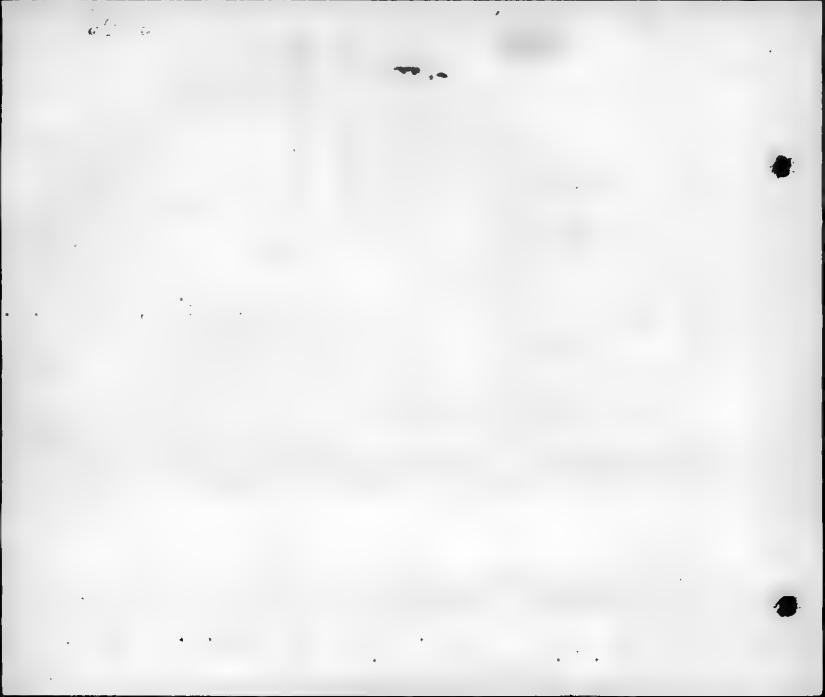


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death. Page 4 may be alread by the haspital or attending physician. TO FUN ALL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filling by the funeral director, page 3 shauld be distorbed for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 shauld be filed with the registrar prior to burial, cremation, or removal, and in olly ellent within 72 hours ofter death.

YS A15 (4) 15M 10/57

| (11) | MARYLAND ST. | ATE DEPARTM | ENT OF HEALTH—BALTIMO | ORE, 18 05313 Reg. Dist. No. |
|-------------|--------------|-------------|--|------------------------------|
| CE OF DEATH | her | MARYLAND | 2 USUAL RESIDENCE (Where deceosed lived. o. STATE | |

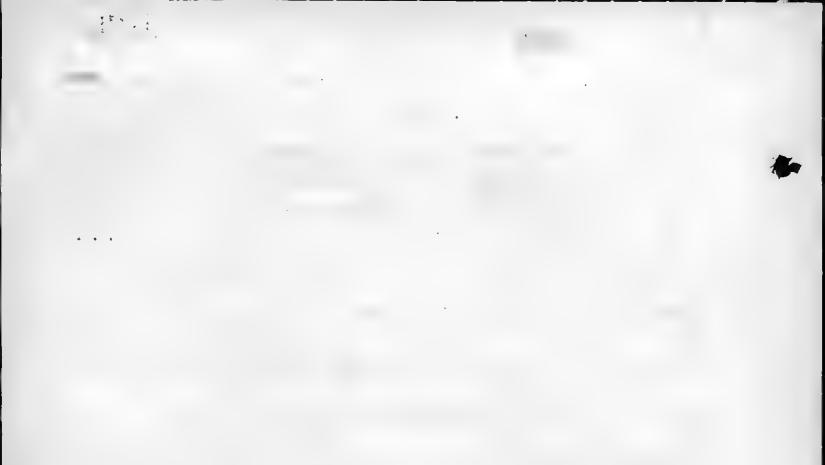
| | 2323 | CERTIFICATE OF DEA | Reg. Dist. No. |
|---|---|---|---|
| | 1. PLACE OF DEATH a. COUNTY | MARYLAND O. STATE | E (Where deceased lived. If institution: Residence before admission) b. COUNTY |
| | b. CITY OR TOWN (If autside corporate limits, write RURA) and give nearest lown) | HOF STAY IN 16 CITY OR TOWN | I (If outside corporate limits, write RURAL and give nearest town) |
| | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d STREET ADDRES | e is residence on a farm? |
| | 3 NAME OF DECEASED (Type or print) | Middle Last | 4. DATE Month Day Yeor OF DEATH 6 / 19 |
| | / W WIDOWED 6 | DIVORCED B DATE OF BIRTH | 19 AGE (In years loss birthdoy) All yts Months Days Hours Min. |
| | 100. USUAL OCCUPATION (Give kind of work done dyring most of working life, even if retired) | JUSINESS OR INDUSTRY 11 BIRTHPLACE IS | Stole of foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| / | Jarries F. Litz I | 14 MOTHER'S MAIDI | Li Vi Berthery. |
| | 15 WAS DECEASED EVER IN U. S ARMED FORCES? 16 SOCIAL SE | CURITY NO. 17 INFORMANT Mrs | Katherine S.Fitzsimmons Avondale Circle Severna Pk.M |
| | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) | (b), and (c)] | INTERVAL BETWEEN ONSET AND DEATH |
| | Canditions, if ony, which gove rise to immediate | 0 20 (S) D G | excenoustose |
| | cause (a), stating the under- | SI- BEXXII | · · |
| | Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUT | ING TO DEATH BUT NOT RELATED TO THE TI | TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO S |
| | OR CONTRIBUTING LI CAUSE OF DEATH | Y INJURY OCCURRED (Enter nature of injury | y in Port I or Part II of item 18.) |
| | ZOC TIME OF INJURY Manth, Day, Year 20d, INJURY OCC Hour o. m., 19 While Not work at war | while factory, street, office bldg., | form, 20f (City or town) (County) (State) |
| | 21. I certify that I attended the deceased fram. | 14/5 G , 19 , to and that death accurred at 130 | M from the course and as the date at lead of |
| | ACTUAL POCK P. 14 | SC MAD. SC | ADDRESS (Street, city or lown, stote) ADDRESS (Street, city or lown, stote) DATE SIGNED |
| | PHYSICIAN'S Robert R. # | A-FIN. | rest inter |
| | 220. BURIAL CREMATION, PEMOVAL (Specify) Burial May 4/60 Ba | ME OF CEMETERY OR CREMATORY | 22d. LOCATION (City. lown, or county) (Stote) Balto.Md. |
| | 23, FUNERAL DIRECTOR'S SIGNATURE 4101 Edmond | RESS 240 I | REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE |
| Ŀ | | DAIL | SIMI W TO CLUMM 15, /WALK |



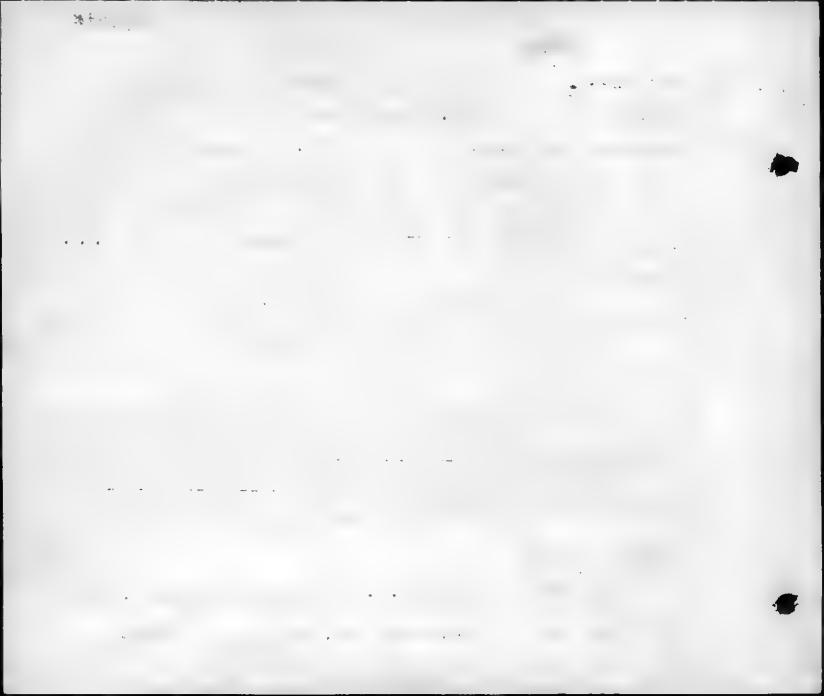
VR A1S (4) 1SM 9/59

05314

|)[| 1. PLACE OF DEATH a COUNTY | 3 - 3 | | MARYL | | o. STATE | | ere deceased | l lived. If institution b COUNTY Ba. | on Residence | e before adr | nission) | |
|------|--|---|------------|--------------------------|-------------|---|----------------|---------------|--------------------------------------|--------------|-----------------|---------------------|--|
| - | b. CITY OR TOWN (IF | | ts write | c. LENGTH OF STAY II | | Mary | | utride corno | rote limits, write R | | | own) | |
| 1 | RURAL and give ner | orest town) | 15, **(1)0 | l vear | r | | | | (Ole IIIIII), WITE | | | ,, | |
| - | Crownsvil | | for stores | 5mo. 15 da | ays | | imore | 22 | | ~ _ | 1 65 | DECIDENICE | |
| | d. NAME OF HOSPITA OR INSTITUTION | | | | | d. STREET ADDRESS o IS RESIDENCE ON A FARM? | | | | | | | |
| | | <u>le State H</u> | ospit | al | | 419 Naple Lane | | | | | | | |
| | 3 NAME OF DECEASED | Fin | \$f | Middle | | la | | 4 DATE OF | Mon | | Day | Yeor | |
| | (Type or print) | | epher | | | F1 | oyd | DEATH | | 5 | 16 | 19 60 | |
| | S SEX | 6. COLOR OR RACE | 7. MARR | IED 🗌 NEVER MARRIED | 8. | DATE OF BIR | H | | 9. AGE (In years last birthday) | | YEAR IF UI | NDER 24 HRS. | |
| | Male | Negro | WIDOWE | D DIVORCED | □ No | vember | 25,18 | | 82 yrs. | THOUGHT'S L | DOYS HOL | 74th, | |
| | 10a USUAL OCCUPATIO | N (Give kind of work ong life, even if retired) | done 10b. | KIND OF BUSINESS OR | INDUSTR | - | , | or foreign co | ountry) | | | T COUNTRY? | |
| 1 | Unknown | ng ma, aron ii remag, | | | | Virg | inia | | | U | .S.A. | | |
| | 13. FATHER'S NAME | | ' | | T | 14. MOTHER | | AME | | | | | |
| | Henry Floy | rd | | 1 | Peg | SY | | | | | | | |
| | 15 WAS DECEASED EVER | IN U.S. ARMED FOR | CE5? 16. | SOCIAL SECURITY NO. | 17 INFO | RMANT | | | Add | ress | | | |
| - 1. | | F yes, give wer or dates of s | | 14-20-6220 | Hos | pital | Record | ds | | | | | |
| F | Unknown | TH Enter only one co | | e for (a), (b) and (c)] | | | | | | | INTERVAL | BETWEEN | |
| | | H WAS CAUSED BY: | | Inamition | n | | | | | | ONSET A | ND DEATH | |
| | W = 1 FE | IMMEDIATE CAUSE (a | | 2110462 0202 | 5 Ab | | | | | | | | |
| - | 3 | DUE TO | Svol | ilitic Car | diova | scular | Disea | use wi | th Centre | al | | | |
| | Canditions, if or | smediate (| | rous System | Syph | 1118 | | | | | | | |
| - | cause (a), stating t | | | | | | | | | | | | |
| | | FREICHIEICANI CON | · | ONTRIBUTING TO DEA | THE BUT SIE | OT DELATED T | O TUCTEBUI | NAL DISEASE | S CONDITION OR | /ENTINE BADT | 1/=1/10 14/ | AS ALITOPSY | |
| | E | ER SIGNIFICANT CON | DITIONS C | ONTRIBOTING TO BEX | 111 601 14 | DI KEDATED 1 | O THE TERM | NAL DISCASI | E COMMINGNON | ENTINIARI | PE | REORMED? | |
| | PART II. OTH PART II. OTH 200. ACCIDENT WA OR CONTRIBUTING IF EITHER, NOTIFY I | 1111050111110 | not perc | TAIRE HOW IN THIS OF | CHOOSE | (5-1 | - £ 2-2 i = E | Deat Lea Dear | t II of them 10) | | YES. | MO 🗆 | |
| | 200. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY) | CAUSE OF DEATH | 200. DESC | CRIBE HOW INJURY OC | CURKED. | Fulet bointe | or injury in t | ran i or ran | i ii or iiem iu j | | | | |
| | | | T | | | P 40 F 10 11 10 10 10 10 10 10 10 10 10 10 10 | | Last int | | - 10 | | (5) | |
| | 20c. TIME OF INJURY | Month, Day, Yes | | | factor | E OF INJURY y, street, offsi | Eblog, orc |) 20f. (City | or town) | (Co | ounty) | (State) | |
| | p. m. | 19 | at warl | Not while | | | | | - 1 | | | | |
| | 21 I certify that | (I) (this hospital |) attend | ed the deceased f | fram | 12/1 | 12 | 58ta | 5/16 | 1960 |) _, that (l |) (we) last | |
| | saw the deceas | ed alive an5/ | /16 | 1960 , and | that dec | oth accurre | d at P. | M, fram | the causes an | d an the | date stat | ed above | |
| | 220, SIGNATURE | - · / 1/- al | 1 | 1 1 | | | | | | | | 22b. DATE | |
| | 1 16 14 18 | 1. K) 45 22 | 4/1. | E Col Manager | M1 | D. PHYS | (G ■ ME | RECTOR . | STAFF PHYS [] | | 5/ | 17/60 ^{ED} | |
| | 22c PHYSICIAN'S NAME (Type) | | 1 | 5 | | 22d. ADDI | RESS | 1 01 | A. Wand | 4-1 1 | (name) o | ~ A | |
| 1 | THURE (Type) | Hildegard I | Heard | Reissman, | M. D. | Crot | WaAIT. | Te pra | te Hospi | PHT 9 H | mary re | Ha. | |
| F | 23a. BURIAL, CREMAT O | N. 236 DATE THEREC | OF . | 23c NAME OF CEME | | | | 23d. LOCA | TION (City, lown, | or county) | (| State) | |
| | REMOVAL (Specify) | May 21,] | 1.960 | Arbutus Mo | moria | al Cemo | etery | Balt | imore, M | arylar | nd | | |
| İ | 24 FUNERAL DIRECTOR'S | SIGNATURE, | | ADDRESS | | | 250. REC'1 | D 8Y REGIST | | STRAR'S SIGI | | | |
| | William | 1. 100 | Vain | -Opec. | | | DATE MA | Y 20'6 | 60 cu | When S. | Kines | | |
| Ì | 91 | c Aims | ret | Que. | | | | | | | | | |



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05316

5331 CERTIFIC

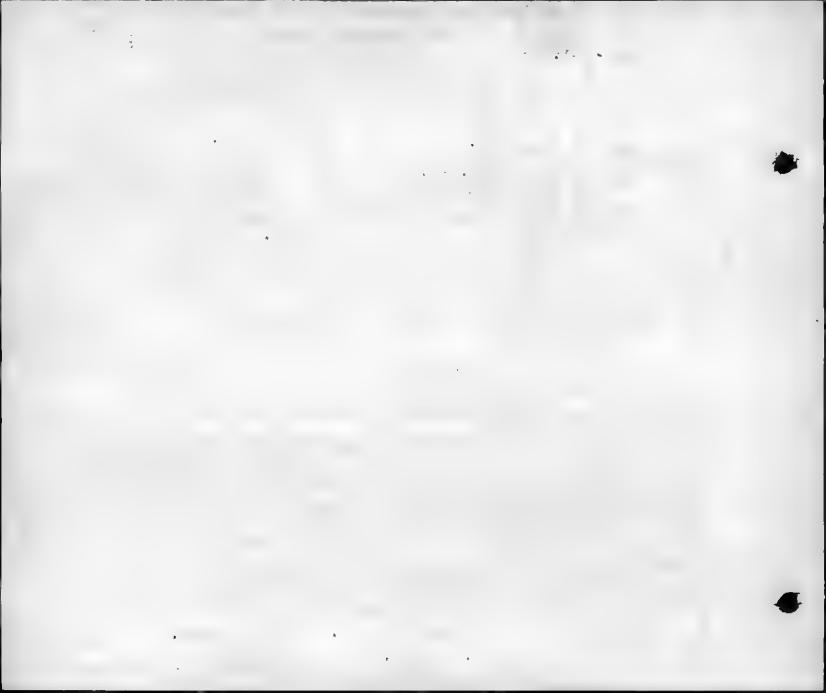
CERTIFICATE OF DEATH

Reg. Dist. No. 27

| 1 | | PRACE OF DEATH COUNTY Anne Arundel MARYLAND | | | | | 2 USUAL RESIDENCE (Who o. STATE Maryland | | COUNTY. | nne A | | - | on) | |
|---|---|---|-------------------------------------|------------------|--------------------|-------------------|---|--------------|---------------------------------|------------|-----------|--------|-------------------------|--|
| | | | outside corporate limit | s, write | LENGTH OF STAY IN | l lb | c. CITY OR TOWN (If or | - | | | | | | |
| | | Odenton | Ft Geo E | | 24 days | | | nton | | | | | | |
| | | OR INSTITUTION | AL (If not in hospitol, gi | ive street od | dress) | i | / d. STREET ADDRESS 3 Duvall Street | | | | | | DENCE FARM? NO IX | |
| | 3 | NAME OF | fin | | Middle | | lost | 4. DATE | | | | | ear | |
| | | (Type or print) | Gert | rude | 6.0 | | Greynolds | OF DEATH | lild') | 7 | Doy 13 | 1 | 960_ | |
| | 5. : | SEX | 6. COLOR OR RACE | 7. MARRIE | D NEVER MARRIED | | DATE OF BIRTH | | 9. AGE (In years lost birthday) | Months | _ | UNDE | R 24 HR5. Min. | |
| | _ | Female | Ou u | WIDOWED | | | 2 July 1884 | | 75 yrs. | | Duy's 1 | 10015 | Will. | |
| | 10a. JSUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired) Housewife | | | lone 10b. KI | ND OF BUSINESS OR | INDUS | | | | | | 'HAT C | DUNTRY? | |
| | 13. | FATHER'S NAME | | 1 | | West Virginia USA | | | | | | | | |
| | | George To | mblin | | | Nancy H | leater | , | | | | | | |
| | 15. | WAS DECEASED EVER | IN U.S. ARMED FOR | CES? 16 SC | CIAL SECURITY NO. | IN | FORMANT Daughte | | Addr | ess | - | | | |
| l | If yes, give wor or dates of service | | | | | | | | | | on. i | Wd. | | |
| _ | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | | | | | | | | | | | | WEEN | |
| | PART I. DEATH WAS CAUSED BY: Cardiac Failure | | | | | | | | | | | AND | DEATH | |
| | | 4630. | DUE TO | | | ~ - | w w | | | - | | | | |
| | | Conditions, if on | | Ar | terioscler | oti | c Coronary Ar | tery | Disease | | | | | |
| | gove rise to immediate couse (a), stating the <u>under-</u> | | | | | | | | | | | | | |
| | _ | lying couse lost. |) (c) | | | | | | | | | | | |
| | CERTIFICATION | PART II OTH | ER SIGNIFICANT CONE | O'TIONS CO | NTRIBUTING TO DEAT | H BUT I | NOT RELATED TO THE TERMI | NAL DISEAS | SE CONDITION GIV | EN IN PART | | PERFO | RMED? | |
| | FICA | 20a. ACCIDENT WAS | LINDERIVING FI | 20h DESCR | IRE HOW INJURY OCC | TIBBED | (Enter noture of injury in F | Part Los Por | et II of item IR) | | 4 | ES DE | ио 🗌 | |
| | | OR CONTRIBUTING | CAUSE OF DEATH MEDICAL EXAMINER) | 200. DESCR | ISE HOW INJURI OCC | UKKED | (Enter notice of injury in r | | ir ii or tiesir te.) | | | | | |
| | MEDICAL | 20c. TIME OF INJURY Hour o. m. p. m. | Month, Doy, Yea | While ot work | Not while | | CE OF INJURY (Home, form, ory, street, office bldg., etc. | | y or lown) | (C | ounty) | | (Stote) | |
| ı | | 21. I certify the | at I attended the | deceased | from 1 | 3 M | ay , 1960 , to | 13 | May , 196Q, | that I las | t saw t | he de | eceased | |
| 1 | | alive an | 13 May | , 19 60 | , and that d | eath | accurred at 1150F | M, from | the causes an | d an the | date s | tated | abave. | |
| | | | 001 | 11 | 1/ | | | ADDRESS (S | itreet, city or town, | stole) | | DATE | SIGNED | |
| | | SIGNATURE | regist. | Brit | sen | ۸ | AD U.S. Army Ho | spita | l, Ft Mea | de, M | 0_13 | _Na; | 7_60_ | |
| | | PHYSICIAN'S FR | ED G. HILKE | ert, c | apt, MC, U | .S. | Army Hospital | , Et | Geo G Mea | ide, M | d 13 | Maj | y 60 | |
| | 220 | BURIAL, CREMATION PEMOYAL (Specify) | N, 226. DATE THEREO | F | 22¢ NAME OF CEMETE | RY OR | CREMATORY | 22d. LOCA | TION (City, town, o | or county) | Ca | (Stote | :) | |
| | - 3 | BURIAL | | 760 | BLACKBUE | RN | CEMETERY | ORL | ANDO, | GILM | | 4. V | /A - | |
| | 23. | FUNERAL DIRECTOR'S | 1) 144 | | ADDRESS 320 | 0-R | I.AVE. 240. REC'E | D BY REGIS | TRAR 246, REGIS | TRAR'S SIG | NATURE | | | |
| | Ľ | party 4 | union /f | ome: | mt. | Ro | ercler Smalate MA | Y 16'6 | 60 0 | 11 . 9 | 1 | | | |

page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the registrar priar to burial, cremaion, ar remaval, and in any event within 72 hours after death. urs after death. Page 4 may be clined by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 VS A15 (4) 1SM 9/SB



MARYLAND STATE DEPARTMENT OF HEALTH

5351

CERTIFICATE OF DEATH

05318

| | 1. P | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) |
|---|---------------|--|--|
| Л | 1/2 | The Flower OFL MARYLAND | L-L-NDIPNA b. COUNTY LAIL 12 |
| | Ь | CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) |
| | / | DURAL and give marest town) | 1 - AR |
| | | d. NAME OF HOSPITAL (If not in haspital, give street address) | d. STREET ADDRESS |
| | | OR INSTITUTION, OTTE 2 PL | 125-31-31-36-36 PIPE YES TINO FILE |
| | 3 N | NAME OF First \U / / Midelle | Lost 4. DATE Month Day Year |
| | Ē | OFCEASED (Type or print) HUGO Wilhelm? | HOLAT OF ATILY 12 1964 |
| | 5. S | 6. COLOR OR RACE 7 MARRIED NEVER MARRIED | B. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min. |
| | 10 | DIVORCED DIVORCED | (iil x 2, 1000 79 m |
| | 10a | USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUS | TRY 11/ BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? |
| | (1 | Curis Kie FUC PARIL | Sheden CAA. |
| | 13. | FATHER'S NAME | 14-MOTHER'S MAIDEN NAME |
| | | 11/ BO/M 176/M | Million & DECI- (ill) |
| | | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. IN | FORMANT 177 // / Address 7 7 1 6 16 cl |
| | | NO - 37403-95,4 | 11 Ll. 1/2/29 6-1+ N 22 23-0 hoju |
| / | | 1B. CAUSE OF DEATH [Enter anly one cause per line for (a), (b), and (c)] | INTERVAL BETWEEN ONSET AND DEATH |
| | | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | TAILURO- TAILURO |
| | 17 | DUE TO | |
| | | Conditions it was which \ 2014 175 | Jular Accident 16 has |
| | | gave rise to immediate (| 1 / |
| | | tying cause last (c) (c) (c) (c) (c) (c) | + 276210 SCERONIS /12/28 |
| | Ω | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| | CAT | X2/2. /3/4 | YES NO |
| | CERTIFICATION | 206. ACCIDENT WAS UNDERLYING /206. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH | O. (Enter nature of injury in Part I or Part II of item 18) |
| | | (IF EITHER, NOTIFY MEDICAL EXAMINER) | The second secon |
| | MEDICAL | F = - | ACE OF INSURY (Hame, farm, 20f. (City or town) (County) (State) tory street, affice bidg., etc.): |
| | WED | Haur a.m. White Natwhite fac | any street, office blog , etc.) |
| | | 21. I certify that (I) (this haspital) attended the deceased from | -1 . 1900, to 1 . 190, that (1) (we) fast |
| | | saw the deceased alive an | eath accurred at AM, from the causes and an the date stated above. |
| | | 22a SIGNA)URE | ATTENDING TED STAFF SIGNED |
| | | JUS Muchan | M.D. ATTENDING DIRECTOR STAFF PHYS. 310NED PHYS. 310NED |
| | ~ = | NAME (Type) | 22d ADDRESS |
| | | NI/XICHPA | 17/1 COTYCCI 1800 - 7/2 |
| | 23a | BUR AL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OF | R CREMATORY 23d. LOCATION (City town, ar county) (5tate) |
| | 1 | BURIAL (Specify) MAY 16 1960 GBAC CLAN | D Cem. ChicAgo Illinois |
| | 24. | FUNERAL DIRECTOR'S SIGNATURE 9 1 LUNDORESS | 250. REC'D BY REGISTRAR 296 REGISTRAR'S SIGNATURE |
| | 1 | HOPPING + KIRMLEK Glen BURN | 10 Md. DATE MAY 16'60 arthur & Kroug |
| | - | | 104.11 |

O HOSELAL DR ATTENDING EHYTICIAN: The low Equires that the death certificate be executed within 21 hours after death. Tage 4 may in alined by the haspital or attending physician.
O FUN --- DIRECTOR: After this certificate has been signed by the attending physician and completely fill --- by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Baard of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOS

VR A15 (4) 15M 9/59

 $\sum_{i=1}^{N} |\mathcal{S}_{i}|^{-iQ_{i}}$.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5352

CERTIFICATE OF DEATH

Reg. Dist. No.

05319

| | | Keg. Dist. No. | | | | |
|---|--|--|---|--|--|--|
|) | 1. PLACE OF DEATH O. COUNTY Come Christial MARYLAND | - Maryana Circi | | | | |
| | b. CITY OR TOWN (If outside carporate limits, write RURAL one give, represent town). | c. CITY Of TOWN All outside corporate limits, write RURAL and give nearest lawn) | | | | |
| | d. NAME OF HOSPITAL (If not in haspitol, give street address) OR INSTITUTION | d STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES NO | | | |
| | 3. NAME OF DECEASED (Type or print) John E. Middle | TOPKINS 4. DATE OF MONTH | 6 19 60 | | | |
| | 5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | PAGE (In years IF UNDER 1 YE AGE (In years IF UNDER 1 YE AGE (In years IF UNDER 1 YE) Months Day | AR IF UNDER 24 HRS ys Hours Min | | | |
| | 100 USUAL OCCUPATION (Give kind of wark done) 10b. KIND OF BUSINESS OR INDUS during most of working life; even if retired) | TRY 11 APPTHPLACE (Stole or foreign Country) 12. CITIZEN | OF WHAT COUNTRY? | | | |
| | James T. Wapkins | Elizabeth Neut | 5 | | | |
| | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (15 yes, 1949 war or dates of service) 218-36-8822 Acrice The office of services | | | | | |
| | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), onch (c).] PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gove rise to immediate | hemorrhage carclio-vascular desare | years | | | |
| | tying couse last. Cause (o), stating the under tying couse last. (c) and diah | eter meditur | years | | | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY PERFORMED? YES NO | | | | | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 14 19. WAS AUTOPSY PERFORMED? 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) | | | | | |
| | | CE OF INJURY (Home, form, 20f. (City or town) (Countery, street, office bldg., etc.) | (Stote) | | | |
| | 21. I certify that I attended the deceased from 2/1/60, 19, to 5/60, 19, that I last saw the deceased alive on 15/5/60, 19, and that death occurred at 4 0.5 M, from the causes and on the date stated above. DATE SIGNED | | | | | |
| | PHYSICIAN'S NAME (Typo) | SHADY SIDE, MD. | 5/20/60 | | | |
| | 270 BURIAL CREMATION, 226 DAJE THEREOF 220 NAME OF CEMETERY OF REMOVAL (SACCION) | CCREMATORY 22d/LOCATION (City, town, or county) | Stote | | | |
| | 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESSY GOVERNMENT GOV | 240 REC'D BY REGISTRAR 246. REGISTRAR'S SIGNA WELL DATERAY 2 3 '60 Orthur & the | • | | | |

may etained by the haspital or attending physician.

2 FU AL DIRECTOR: After this certificate has been signed by e attending physician and completely film by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 haurs offer detain. TO HILL IAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 TO F VS A15 (4) 15M 9/5S



MANYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. COUNTY 主撰 delay is necessary, meral director. Page b. COUNTY Anne Arundel Anne Arundel files MARYLAND Marvland b. CITY OR TOWN lif outside corporele limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outs'de corporete limits, write RURAL and give nearest town) Soard of h write RURAL and give neerest town! Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d STREET ADDRESS #4. Box #11 retained State Rt. #4, Box #41 3. NAME OF Middle DATE Month DECEASED OF uld be executed within 24 hours after death. If in pencil in Item 18. Give Pages 1, 2, and 3 to 1. Office along with form PM3. Page 5 may be requirel-transit permit. File pages 1 and 2 with the ways and In any event within 72 hadrs after (Type or print) DEATH May CHARLES HUNT 6. COLOR OR RACE T. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR last birthday) Months WIDOWED D. VORCED ATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY Office along with form PM3. Page burial-transit permit, File pages 1 and most of working I fa. even if ratired) MOTHER'S MAIDEN NAME MEDICAL EXAMINER: This certificate should be executed within IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) | (If yes give we rondetes of service) 18. CAUSE OF DEATH [Enter enly one cause per line for [e], (b), and (c),] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent pericarditis **POKOO**X removal, (b) Bronchopneumonia "pending" geve rise to immediate causa execute the certificate, writing the word "pending" and be forwarded to the Chief Medical Examiner's VERAL DIRECTOR; Page 3 should be used as a **DUE TO** (a), stating the underlying causa last. cremation, PART II. OTHER SIGNIF, CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a), 19. WAS AUTOPSY CERTIFICATION 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of Injury in Part I or Part II of item 18.) PRIMARY IT or CONTRIBUTING IT CAUSE OF DEATH. 20c. TIME OF INJURY 20d. INJURY OCCURRED : 20u. PLACE OF INJURY (Homa, form, Month, Day, Year 201. (City or lown) fectory, street, office bldg., etc.) Not While Hour a.m. el work af work prior 21. I certify that I took charge of the remains described above, held an Autopsy X. Inspection agent, death resulted from: Undetermined manner Suicide Natural causes Accident Homicide CHIEF MEDICAL EXAMINER 50 designated ACTUAL ASSISTANT MEDICAL EXAMINER should be for FUNERAL 1 SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** S. Fisher, M.D. Russell should I NAME (Typa) Address (Streat, city, town, or county) 228, BURIAL, CREMATION, 225, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) <u>g</u> 4 0 24a. REC'D BY REGISTRAK VS. A15ME 5M 7/59

. IS RESIDENCE ON A FARM?

YES NO

1960

IF UNDER 24 HRS.

Yeer

Hours

ONSET AND DEATH

PERFORMED? NO [

(Stata)

and in my opinion

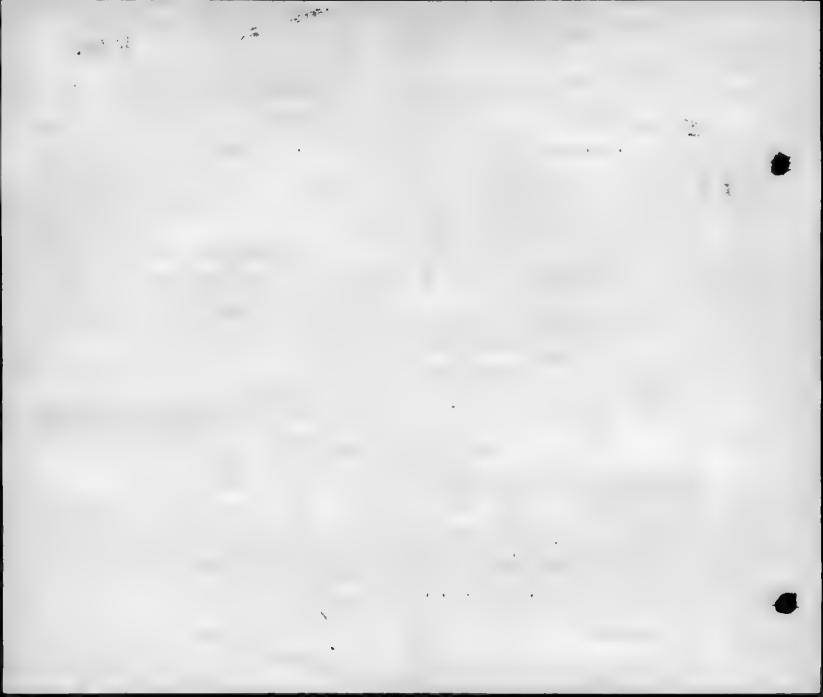
DATE SIGNED

(State)

5/23/60

(County)

12. CITIZEN OF WHAT COUNTRY?



DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND 5353 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) Anne Arundel G. STATE Maryland b. COUNTY MARYLAND Baltimore City (<u>1</u> b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest tawn) RURAL and give negrest town) vears Baltimor e Crownsville 2mo. 9 days d NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS IS RESIDENCE Crownsville S. ate Hospital 726 Harford Avenue YES NO NAME OF Middle DATE OF DEATH Month Veor death. Sara (Type or print) Mae 1960 59, 2 6 COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX B DATE OF BIRTH after Months Dovs Hours DIVORCED [WIDOWED 7 Female 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Unknown U.S.A. Unknown 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mitchell Bethay Rachel Steele 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address Unknown Hospital Records Unknown any 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH 9 PART 1 DEATH WAS CAUSED BY:
(MMEDIATE CAUSE (g) Hypostatic Bronchopneumonia puo DUE TO Right Hemiplegia remayal, Conditions, if any, which (b) gave rise to immediate **DUE TO** couse (o), stating the under-Syphilitic Cardiovascular Disease lying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY cremation, PERFORMED? YES 📮 NO 📋 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) Day Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) of work of work 21. I certify that (1) (this haspital) attended the deceased from 2/22 1960_, that (I) (we) last A.M. fram the causes and an the date stated above. ond that death accurred at saw the deceased alive an SIGNED ATTENDING PHYS MED. STAFF PHYS. M D 22c. PHYSICIAN'S 22d, ADDRESS NAME (Type Reissman. Crownsville S. ate Hospital, Maryland Hildegard M. D. BURIAL, CREMAT ON, 23b (State) PEMOVAL (Spenify) FLINERAL DIRECTOR'S SIGNATUR **ADDRESS** 25a. REC'D BY REGISTRAR 25h REGISTRAR'S SIGNATURE a hin & Thrus

MARYLAND STATE DEPARTMENT OF HEALTH

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be Kiled

funeral

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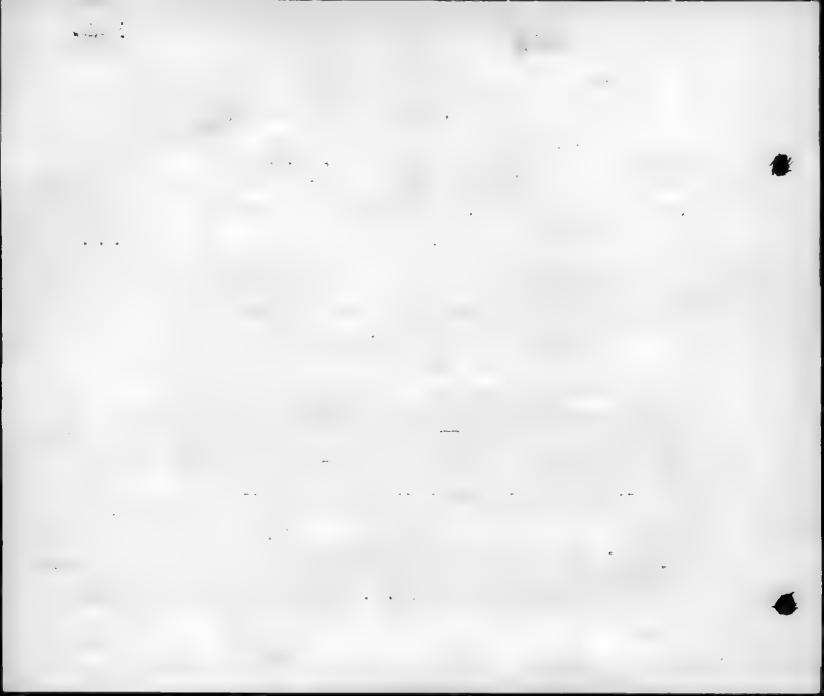
DIRECTOR:

5 S

0

VR A1S (4)

physician mave carl

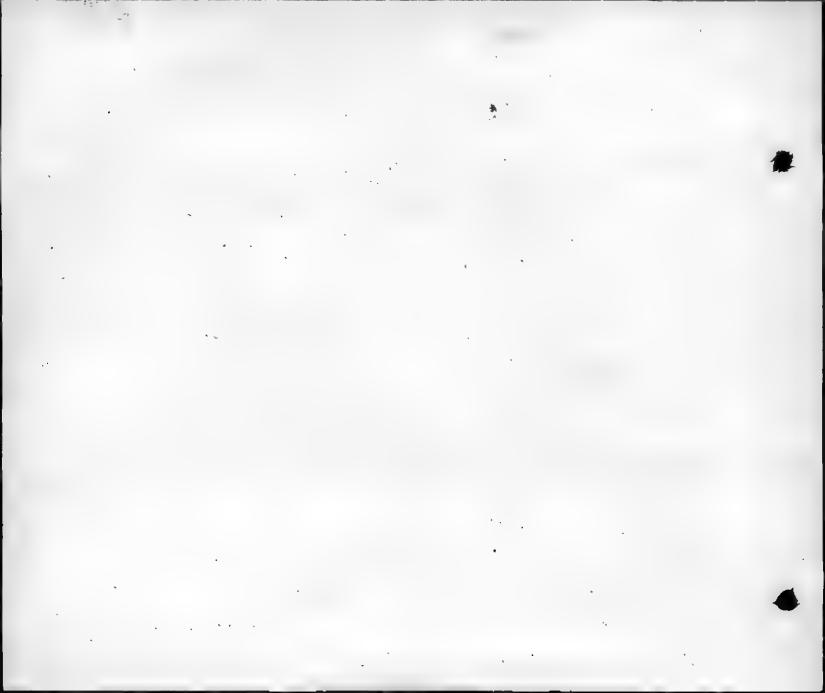


VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05322

| 5354 | CERTIFICATE | OF | DEATH |
|--|-------------|----|-------|
| The same of the sa | | | |

| | - CON CERTIFIC | - | 67 917 7111 | Reg. Dist | . No. | | |
|---|--|---|------------------------------------|-------------------------------------|---|--|--|
| | PLACE OF DEATH O. COUNTY MARYLA | O STATE | TENDENCE (Where pocease | d fived - If institution: Residence | before edmission) | | |
| | b, CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN RURAL and give nearest town) | 1 1b c. city/o | OR TOWN (If outside corp. | prote limits, write RURAL and or | | | |
| | d. NAME OF HOSPITAL (If not in hospital, gife street address) OR INSTITUTION | d. STREI | ET ADDRESS | , /- | e. IS RESIDENCE ON A FARM? YES NO | | |
| | NAME OF DECEASED (Type or print) Addle | Lack | Ligst 4. DATE OF DEATH | | Doy Year 1960 | | |
| 5 | SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED WIDOWED DIVORCED | | 5-1900 | 60 yrs. | Poys Hours Min. | | |
| 100 | USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR during most of working life, even if retired) | INDUSTRY TE BIRT | CHPLACE (State or foreign of CALL) | country) 12 CITIZ | S A | | |
| 13. FATHER'S NAME COUNTY E, Hall 14. MOTHER'S MAIDEN NAME MAGGIC Hall | | | | | | | |
| | WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. (If yes, give wor or dates of service) | HOFORMANT | ie Sha | D. Harwo | od mod | | |
| Г | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | | , | 1:- | INTERVAL BÉTWEEN ONSET AND DEATH | | |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | ux h | rezert w | re h | | | |
| | Conditions, if only which) (b) Size 20 1 7 | - w | to a | 7 ans | 11200 | | |
| | gove rise to immediate couse (a), stating the under-lying couse lost. | | | | | | |
| CATION | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH | H BUT NOT RELATES | D TO THE TERMINAL DISEA: | SE CONDIT ON GIVEN IN PART | 1(a) 19 WAS AUTOPSY PERFORMED? YES NO | | |
| CERTIF | 206. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | URRED. (Enter natu | re of injury in Port I or Po | rt (I of item 18.) | | | |
| MEDICAL | 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of work | 0e. PLACE OF INJU foctory, street, o | RY (Home, form, ffice bidg., etc.) | y or town) (Co | ounty) (Stote) | | |
| | 21. I certify that I attended the deceased fram | 19 | | , T9,that I las | t saw the deceased | | |
| | alive an, 19, and that death accurred at, M, from the causes and an the date stated above. | | | | | | |
| | ACTUAL SIGNATURE 6 6 6 6 6 6 | M.D | | Street, city or town, state) | DATE SIGNED | | |
| | PHYSICIAN'S A TI A LLIY | _ 6 | 211647 | pay str f | | | |
| L | OF BURIAL, CREMATION, 276. DATE THEREOF 22c. MAKE OF CEMETE REMOVAL (Specify) 6 3 - 1960 CO | ERY OR CREMATOR | Y 22d LOC | TION (City, town, or country) | M Stotel | | |
| 23 | TUNERAL DIRECTOR'S SIGNATURE ADDRESS | n mail | 24g. REC'D BY REGIS | TRAR 246 REGISTRAR'S SIG | NATURE Thousa | | |

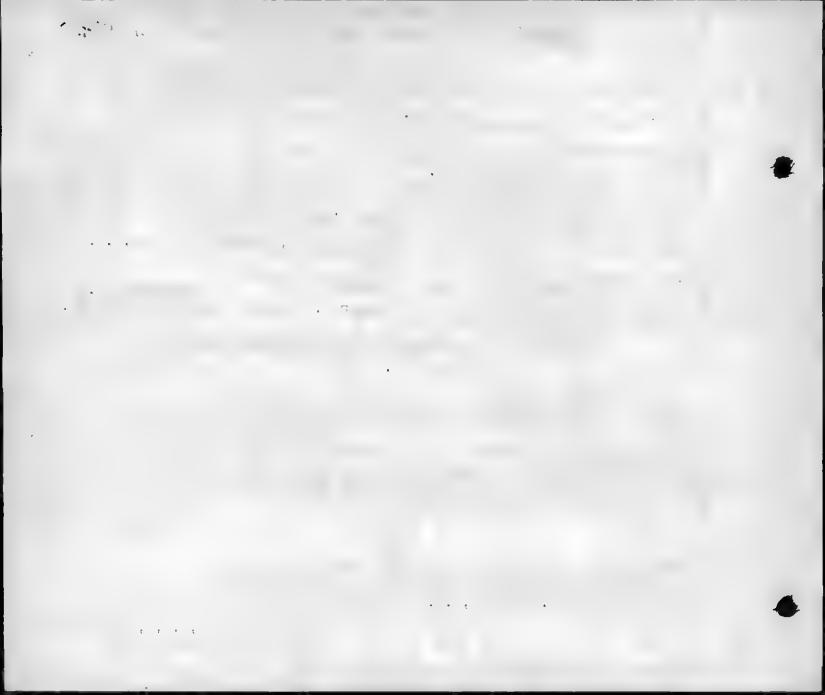


VS. A15ME(5) 5M 9/55

| MARYLAND STATE | | | | |
|----------------|----------|-------------|----------|--|
| 535MEDICAL EX | AMINER'S | CERTIFICATE | OF DEATH | |

8 05323 Reg. Dist. No.

| PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
|---|---|
| Anne Arundel MARYLAND | "Marvland b. comme Arundel |
| b. CITY OR TOWN (If outside corporate limits, write RURAL c., LENGTH OF STAY IN 15 and give nearest town) | c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) |
| Gibson Island 12 Yrs. | X Gibson Island |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | / d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| Skywater Road | Skywater Road YES NO 13 |
| 3. NAME OF First Middle DeceaseD Adeline D. | Johnson of A. Date Month Doy Year |
| (Type or print) Adeline U. | DEATH 31 May 19 60 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED [] | DATE OF BIRTH 9. AGE (In yours IF UNDER 1YEAR IF UNDER 24 HRS. |
| Itamala liibita | 3Aug. 1909 SD yrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if refired) | |
| House wife Own Home | Portland, Maine U.S.A. |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Daniel Dickey | Lela Payson |
| | NFORMANT 607 ENERgreen Rd. |
| | ysom O. Johnson West Severma Park Md. |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: | and acute barbiturate |
| IMMEDIATE CAUSE (o) ACUTE PENY 118M | ALUKE DATELLUTORE |
| intoxication. | |
| gove rise to immediate cause | |
| (a), stating the underlying DUE TO | |
| | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY |
| FACT II. OTHER SOMMERNY CONDITIONS CONTRIBUTION TO DEATH BUT | PERFORMED? |
| E 200 EVERNING CAUSE WAS | YES NO K |
| CAUSE OF DEATH. | inter nature of injury in Part I or Part II of Item 18.) |
| 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA White Not white of work of | ory, street, office bidg., etc.) |
| 21. I certify that I took charge of the remains described about | ve, held on Autopsy , Inspection x Inquiry x and find that |
| | cide , Homicide , Undetermined cause KX |
| 1 to 1/7 11 5 11 | , Homelet [], Onderenmed cost [] |
| ACTUAL EUStaul KARLESTANI | CHIEF MEDICAL EXAMINER DATE SIGNED |
| SIGNATURE | _M.D. CHIEF MEDICAL EXAMINER |
| EXAMINER'S | DEPUTY MEDICAL EXAMINER \$\(\frac{1}{60} \) |
| PAME (Type) Gustave H. Fautert. M.D. 220. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR | |
| PEMOVAL (Specify) | Cemetery Brooklyn, R.F.D. Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | |
| Reclared V. Sing totan Slew Boun | 9 Md. 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE CILLING & TILLING |



5309

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 ()5324 Reg. Dist. No.

| П | PLACE OF DEATH | Ale | | | | 2 USUAL RESIDE | NCE (WI | ere decease | d lived. If institut | | e before oc | lmission) |
|------|--|--|--------------------------|---|---------|-----------------------|-------------|---------------|----------------------|--------------|---------------------|--|
| | o. COUNTY | nne Arunde | 1 | MARY | LAND | o. STATE | arvl | and | b. COUNT | Anne | e A _v ui | ndel |
| ľ | b. CITY OR TOWN (II | outside corporate limi | ls, write | c. LENGTH OF STAY | IN 1b | c CITY OR TO | WN (If c | outside corpo | rate limits, write | RURAL ond gi | ive negrest | lown) |
| П | RURAL ond give ne | olis | | 1-Man | +4 | 10 A | nnav | olis | | | | |
| ı | d NAME OF HOSPITA | Al (If not in haspital a | ive street oc | ldress) | -4 | d. STREET AD | | | | | e. 15 | RESIDENCE |
| | nne Arunde | L General H | lospit | al | | / 2 | 2 We | st St. | • • | | | S NO D |
| | . NAME OF | Fir | | Middle | | lost | | 4. DATE | | nth | Doy | Yeor |
| ŀ | DECEASED (Type or print) | Louise | | *************************************** | | JOHNSON | | OF DEATH | May | 71019 | 24 | 19 60 |
| - | 5. SEX | 6. COLOR OR RACE | | D D NEVEO MARON | 50 T | B. DATE OF BIRTH | | - | 9. AGE (In years | IF UNDER 1 | | INDER 24 HRS |
| | Female | Negro | WIDOWED | | | August 15 | . 19 | 00 | last birthday) | Months | | urs Min |
| - 1- | 00 USUAL OCCUPATIO | | 1 | - | | | , , | | | | ZEN OF W | HAT COUNTRY |
| | during most of wbrk | ing life, even if retired |) | | , II400 | | ryla | | 0000071 | 3 | U.S. | A |
| - | LAKNOZ | | | | | 14 MOTHER'S N | | | | ` | | 7, |
| | E PAINER S NAME | 1 / - | +-4- | | | A MOTHER'S N | AAIUEN P | NAME | d +- | | 4- | |
| - | EdWAL | Q (20 | | | | VYING | PP | A | 2/01 | VA! | 1 | E 4 |
| | (Yes, no or unknown) (| CIN U.S. ARMED FOR If yes, give wer or dates of s | CES7 16. 50 ervice) | ment I would | | NFORMANT' | 11 | , | Ad | dress A | WA | Md, |
| Ų | 1/0 | | 21 | 5-12-800 | 6_/ | MINERY | 4 / | JAYL | or-22 | -VIAS | 4.5 | <i>t</i> |
| | | TH [Enter only one co | use per line | for (a), (b), and (c). |] | 0 — | | 2 1 | | | INTERVA | L BETWEEN |
| | PART I. DEAT | TH WAS CAUSED BY: A IMMEDIATE CAUSE (d) | -av | cumana) | 15 | tomach | 6/ | WT_1 | Nelasi | TIM | | COLUMN TO THE PARTY OF THE PART |
| - [| 151X | DUE TO | 1 | n | 1. | 21 2 | | , | | 1 . | 91 | THE |
| - 1 | Conditions, if or | | Co | an cre | î | Liver | 160 | 1 road | Celmoh | 1 hours | 1 | Merch |
| - [| gove rise to in | | - / | | 4,1 | 7 | 1 _ ^ | 120 | 11 21 | 1 12 | | |
| H | lying couse lost. |) (c | dur | & Sun | TOA | lecto | 5 | NAS | FILOU! | 2hm | Jay . | |
| | PART II. OTH | ER SIGNIFICANT CON | DITIONS CO | INTRIBUTING TO DE | AH BUT | NOT RELATED TO T | HETERM | INAL DISEAS | CONDITION GI | VEN IN PART | | AS AUTOPSY |
| ı | 5 | | | | V | | | | • | | | NO 🗌 |
| | 200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY | S UNDERLYING [] CAUSE OF DEATH | 20b. DESCR | SISE HOW INJURY O | CCURRE | D (Enter noture of | injury in l | Port I or Por | t II of item 18.) | | | |
| - 1 | ". I | MEDICAL EXAMINER) | | | | | | | | | | |
| -1 | 20c. TIME OF INJURY | f Month, Doy, Ye | | URY OCCURRED | | ACE OF INJURY (He | | | y or town) | (C | ounty) | (Stote) |
| | Hour o.m. | 19 | While of work | Not while of work | " | ciory, sneer, onice i | Jiug., eic | 1 | | | | |
| | 21 I certify th | at I attended the | decenser | dGrom March | 7. | 10 60 | to M | av 24 | 1960 | O that I I | ast saw I | ha decease |
| - 1 | | May 24. | 1960 | | | occurred of 5 | | | | | | |
| П | | | , . ~ | a indi | deom | occorred of 2 | | | treet, city or town | | e dale s | DATE SIGNED |
| | ACTUAL | t. Kel | ron & | ASP) | | 110 | | y St. | | • | | 5/25/60 |
| | SIGNATURE_V | 141 | 70000 | - 101 | | M D. | 0.104 | 4 | £ | | | 11-271-99 |
| | PHYSICIAN'S R. | L. Richard | ison | | | Ann | apol | is, Mo | d. | | | |
| - | 220. BURIAL, CREMATIO | | F I | 22c NAME OF CEM | ETERY A | | | | TION (City, town, | As county! | ****** | (54-4-) |
| | JEMOVAL (Specify) | 5-10- | 60 | Pina | / 44 | AL AZ | | 40 | ALA las | or county) | M | (State) |
| 1 | 3. FUNERAL DIRECTOR'S | SIGNATURE | 00 | ADDRESS | 5/13 | 1 | 24n DEC' | D BY REGIS | 18AR 24h 850 | ISTRAR'S SIG | NATION | <u></u> |
| | 1 FU. | | 1 | i / | 11 | 1 | | | / | Lilling 8 | | |

and 2 should be filed with hours after death; Page 4 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 D FULL KAL DIRECTOR: After this certificate has been signed by the attending physician and completely fit poge 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Page the registrar prior to burial, cremation, ar removal, and in any event within 72 haurs after death. TO HOSP TO FU



certificate

requires that the death

rs after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5356

CERTIFICATE OF DEATH

Reg. Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Anne Arundel a. STATE **b.** COUNTY MARYLAND CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) Washington. D.C. 2 yr.7 mo. Laurel. Md. d NAME OF HOSPITALIS CHI CONTINUE THE TRANSCHOOL CHILDREN'S Center d. STREET ADDRESS IS RESIDENCE ON A FARM? #9 Knox Circle S.E. YES NO 13 NAME OF Middle 4. DATE Month Day DECEASED 1960 Vaughn Eugene Johnson May DEATH (Type or print) S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 1 8 DATE OF BIRTH 9. AGE [In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Manths Days DIVORCED April 6. 1952 male WIDOWED | Negro yrs. 10a. USUAL OCCUPATION (Give kind of work dane)
10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)
during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? Washington, D.C. USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles Wade Johnson Jean Elizabeth Johnson WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address Children's Center, Laurel, Md. 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH Aspiration Pneumonia PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Spastic Quadriplegia Conditions, if any, which gave rise to immediate **DUE TO** couse (a), stating the under-Mental Retardation lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO A 20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port It of Item 18.) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (State) (County) factory, street, office bldg., etc.) Haur o. m Not while at wark at work 21. I certify that I attended the deceased from November 1, 1957, to May 22, 1960, that I last saw the deceased and that death accurred at 10:50 PM, from the causes and on the date stated above. alive on May ADDRESS (Street, city or town, state) ACTUAL Children's Center, Laurel SIGNATURE PHYSICIAN'S Boyland Children's Center, Laurel, Md. James E. NAME (Type) 22o. SURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) May 25. 1960 District Training School Burial Laurel. Maryland 24g, REC'D BY REGISTRAR 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b. REGISTRAR'S SIGNATURE arthur S. House

DIRECTOR: ō NO ION

VS A1S (4) 1SM 9/S8



| 1. | · I | ite | m 18 Film26 | ² MÄRYLÄ | ND S | TATE DEPAR | TME | NT OF H | EALT | H-BALT | MORE, | 18 | | | |
|--|------|---------------|--|---------------------------|-----------------|-------------------------------------|---------|-----------------------------------|---------------------------|------------------------|------------------------------------|-------------|---------|----------------|---------------------|
| 00. 8 % | X | | 53 | 310 MEE | DICA | L EXAMIN | ER'S | CERTIF | ICA | re of D | EATH | Reg. | 32 | 5 | |
| should | 1 | 1. | LACE OF DEATH | Bunda | / | MARY | LAND | 2. USUAL RES | , | Where deceased and | lived. If Institu | | | | ission) |
| Sory. | / | t | CITY OR TOWN It outside and give nearest town) | corporate Kmils, write it | TURAL | c. LENGTH OF STAY | N 1b | c. CITY OR | TOWN (If | autside corpare | | | | | wn) |
| neces tor. I | | | Annapllis NAME OF HOSPITAL OR | INSTITUTION (IF | not in hos | pital, give street address | } | d. STREET A | S ad e | IIa | | | | e, IS R | ESIDENCE A FARM? |
| Pri pri | , 11 | _ | OA Anne Aruno | del Gener | al | | | / Rt 8 | | 28 | | | | YES [| NO 🔼 |
| nny de ycey positre | | | PECEASED Type or print) | Clude | | Middle | | Joues | | 4. DATE OF DEATH | Month 5 | _ | Doy | | 960 |
| the further the re- | | 5. \$ | | | - MARRIE | | | DATE OF BIRTH | | | AGE (In years as birthday) 35 yrs. | Months | Days | Hours | ER 24 HRS. Min. |
| deoth d 3 to retoine 2 with | | 10a | Male WI USUAL OCCUPATION (Gi uring most of working life, | ve kind of work do | ne 10b. K | IND OF BUSINESS OR | NDUST | RY 11. BIRTHPL | ACE (State | ar fareign coun | | | | WHAT | COUNTRY |
| 2, on ay lle | | 13. | painter FATHER'S NAME | | sh | ip building | | 14. MOTHER'S | | e, lowa | | US | SA. | | |
| 24 houn Pages 1, 3ge 5 = 8 | / | 15 | Earl M. a | | Eco 114 | SOCIAL SECURITY NO. | 117 16 | Silvie | a May | Herric | E. Address | | | | |
| Pog File | | | no, or unknown} [if yes, | give wor or dates of ser | vice) | 2 28 8308 | 1 | s Glady: | s '⁄oo | re-Sist | | Grind | dall | St. | |
| ed with G18. G h PM3. | | | 18. CAUSE OF DEATH [ER | S CAUSED BY: | | for (a), (b), and (c).] | eri | osclare | neie | with c | | imore | | | ren la n |
| Item Item h form | | | 4 / | DIATE CAUSE (a) . DUE TO | | the left | | | | | | | | | |
| d be call in significant signi | | | Canditions, if any, w gave rise to immediate o | ouse (| | | | | | | | <u> </u> | | | |
| shouling per e ofor a bur | | | (a), stating the underli | (c) | | lmonary co | | | | | | | | | |
| ificote ding: s Offic sed on | | CERTIFICATION | PART II. OTHER SIG | SNIFICANT CONDI | TIONS <u>CO</u> | ENTRIBUTING TO DEATH | 18UT N | OT RELATED TO | THE TERM | INALDISEASE C | ONDITION GIV | 'EN IN PAI | | PERFO PERFO | AUTOPSY PRIMED? |
| d 'pen'd' miner | 1 | CERTIFI | 20a. EXTERNAL CAUSE W. PRIMARY ☐ or CONTRIBU CAUSE OF DEATH. | AS 20b. | DESCRIBE | HOW INJURY OCCUR | RED. (E | nler nature of in | jury in Par | 1 1 or Part It of | tem 18.) | | | | |
| NER: TI | | WEDICAL | Haur o, m, | Month, Day, Year | | NJURY OCCURRED 20 Not while at work | e. PLAC | E OF INJURY (Firy, street, affice | tome, form bidg., etc. | 20f. (City or | tawn) | (Co | sunly) | | (State) |
| ing fl Medi Poge | | 2 | p. m. 21. I certify that I | | | | abo | ve, held an | Autops | y 🔀, losp | ection, | Inqui | ry 🔲 | and | find that |
| AL EX P. writ Chief TOR: |) | | death resulted from | n: Natural co | ouses [|], Accident [], | Suid | ide 🔲, H | omicide | Unde | etermined o | ause [|]. | | |
| AEDIC tificoto o the | < | | ACTUAL SIGNATURE | will be | 2XX | Andrew | | _M.D. CHIEF M | EDICAL EX | CAMINER - | | | | _ | SIGNED |
| Ged 1 | | | EXAMINER'S NAME (Type) | | Or | Lovitt | | | | AL EXAMINER [| 3. | 3 | = , | 5 - | 50 |
| cute forw O IIUI | R. | 220 | BURIAL CREMATION, 22 REMOVAL (Specify) Val-Burial M | ay 6,196 | | 22c. NAME OF CEMETE | | CREMATORY in | | Beone, | N (City, town, | or county) | | (Stat | e} |
| YS. A15ME(5) | 72, | _ | PUNERAL DIRECTOR'S SIGN | | ZV | ADDRESS | | 211 | | D 8Y REGISTRAL | 245. REG! | | | | |
| 5M 9/5S | * | - | Hopping Fun | eral lives | 6 .A | annapolis. 1 | Mary | land | DATE N | AY 1 0 '50 | G. | م الستالم | J. Then | KA. | |



1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

e IS RESIDENCE ON A FARM?

30

Days

(County)

Manths

IF UNDER 1 YEAR IF UNDER 24 HRS

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

YES NO

that (I) (we) lost

(Stote)

Marvland

22b DATE 160 GNED

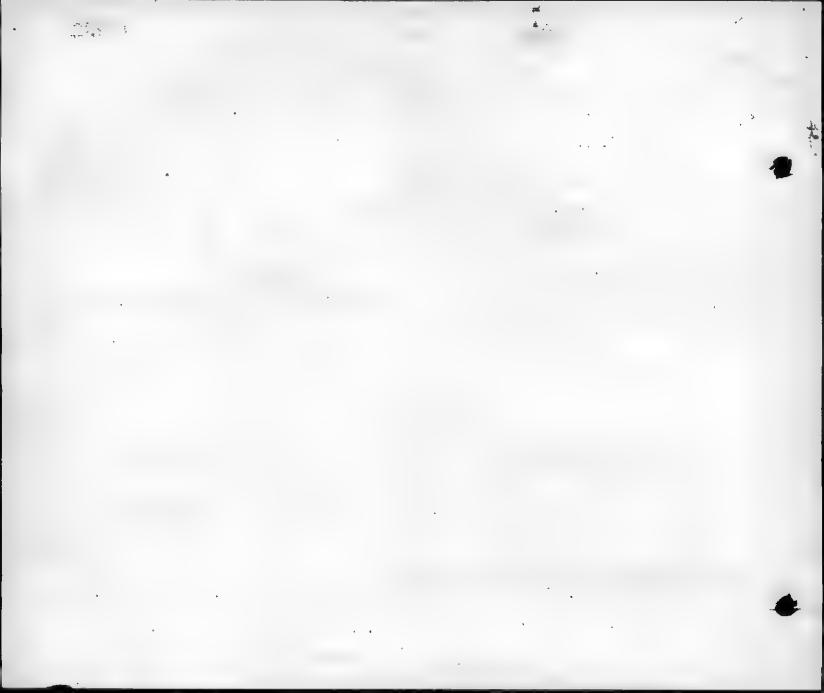
(State)

YES NO I

Yeor

1960





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05328

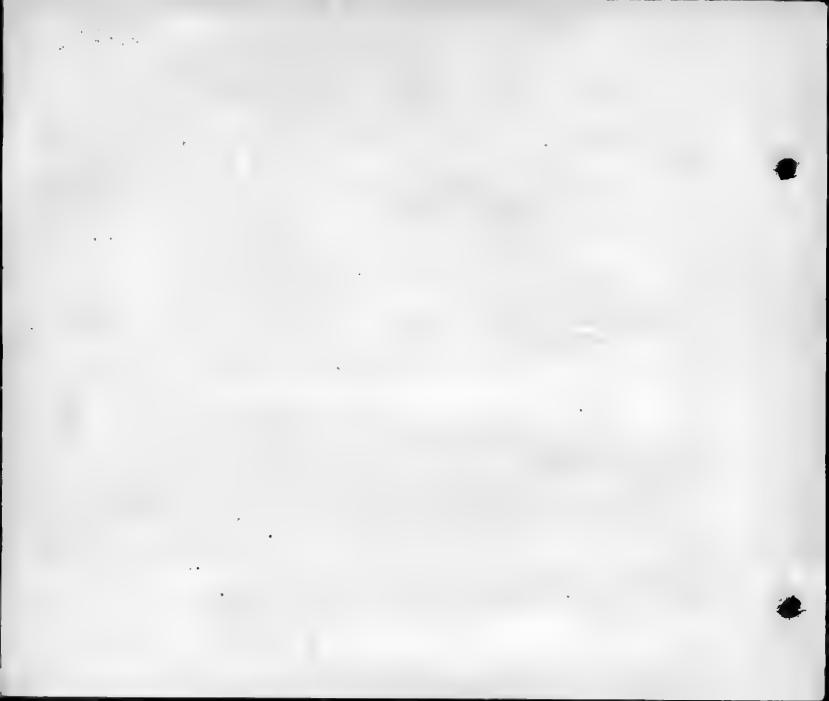
5311 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | |
|--|--|-------------------------------|
| 1. PLACE OF DEATH 0. COUNTY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence a. STATE b. COUNTY | e before admission) |
| Anne Arundel | | Arundel |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If autside carporate limits, write RURAL and gi | ve negrest fown) |
| Annapolis | /O Annapolis | |
| d. NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION | / d. STREET ADDRESS | e IS RESIDENCE |
| 305 Chesapeake A.e., | 305 Chesapeake Ave., | YES NO TA |
| The state of the s | | |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Month | Day Year |
| (Type or print) Evelyn | KING DEATH May | 27 1960 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | | YEAR IF UNDER 24 HRS. |
| Female White WIDOWED DIVORCED | Gland 19 19/19/19 So yrs. Months | Doys Hours Min. |
| 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDU | | ZEN OF WHAT COUNTRY? |
| during most of working life, even if retired) | Maryland | U.S. |
| youse whe some | <u> </u> | 0.812.6 |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| Milliam G. Lowman | (Inna 6. 1, remiford | |
| | NFORMANT / Address / | 21 |
| (Yes, no. or unknown) [(If yes, give wor or dates of service) | Serius 1. Hence | 2) |
| | Court III | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | 1. | ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Definition | - premovic | 1 mon |
| DUE TO | | |
| Conditions, if any, which) (b) Cancer of | esopherin | 1/22. |
| gove rise to immediate | | 1 |
| cause (a), stating the under- | | |
| lying couse last. (c) | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART | Ho) 19 WAS AUTOPSY PERFORMED? |
| | | YES [] NO [] |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER) | D. (Enter nature of injury in Part I or Part II of item 18.) | |
| 205. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRE OF DEATH 205. DESCRIPE OF DEATH 205. DESCRIBE HOW INJURY OCCURRE OF DEATH 205. DESCRIBE HOW INJURY OCC | | |
| | | |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED to the late of work at work | ACE OF INJURY (Hame, form, 20f. (City or town) (Cotary, street, affice bldg., etc.) | ounty) (State) |
| p. m. 19 at wark at wark | | |
| 21. I certify that I attended the deceased from U-30 | . 10 0 to May 26, 1960 that I le | ast saw the deceased |
| | | |
| olive on May 26, 19 60, and that death | occurred of 7:40A M, from the couses and on th | |
| | ADDRESS (Street, city or town, state) | DATE SIGNED |
| SIGNATURE RANKS SUITE | MD 121 Cathedral St. | 5/27/60 |
| | | |
| PHYSICIAN'S Frank M. Shipley | Annapolis, Md. | |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY O | OR CREMATORY 22d. LOCATION (City, town, or county) | (State) |
| #FEMOVALISmeciful 1 ch | 1 1 7- 1 1 1 2 | . (Signet |
| 13 mil May 30-1920 Af Clm | es Comelia Annatolio | 1100. |
| 23. EUNERAL DIRECTOR'S SIGNATURE | 240. REC'D BY REGISTRAR 246. 9EGISTRAR'S SIG | |
| Joen 14. veyar sus america | DATE MAY 31 60 Circlus | S. Kraus |

TO HOWN ALOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may trained by the hospital or oftending physician.

TO FULL ALDIRECTOR: After this certificate has been signed by the attending physician and completely filter has been discreted from the page 3 shauld be detached for use as the burial-transit permit. Then please remane carbon papers. Pages I and 2 should be filted with the registrar prior to burial, cremation, at remanal, and in any event within 72 hours after Death. TO FU VS A15 [4] 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5359

CERTIFICATE OF DEATH

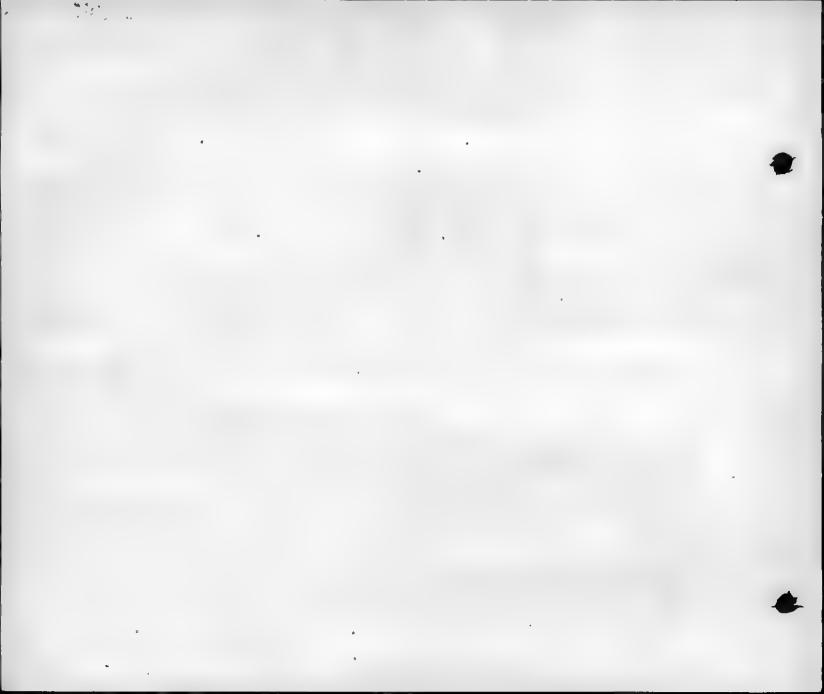
05330

| | | | | | | | Reg. Dit | | | |
|---|--|--|---|---|--|--|--|--|---|---|
| ANNe Arunde | :1 | MARYLAND | 2 4 | SUAL RESIDENCE (WE STATE Larylan | ere deceased | lived If institution b. COUNTY | n-Residenc AA | e before | admission) | |
| (If autside corporate limits, nearest lower) | write c. LENGT | H OF STAY IN 18 | 5 | Erooklyn | | rate limits, write RL | IRAL and g | ive neare | ist fown) | |
| lula | | | 1 | | thew A | lve. | | | IS RESIDEN ON A FAR YES NO | RM? |
| Edwa | rd | Middle L• | | Kosack | 4 DATE OF DEATH | Mont 5 | h | 18 | Year | 60 |
| | | VER MARRIED [| | | | 9. AGE (In years loss by the day) yrs. | | | | 4 HRS Min. |
| ON (Give kind of work dor rking life, even if retired) | | | USTRY | | | untry) | 12. CITI. | ZEN OF | WHAT CO | UNTRY |
| Lwarence | | | 14. | | | eber | | | | |
| | | CURITY NO. 17 | INFOR | MANT Family | | _ | | | | |
| ATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO DUE, which the under the under (c) | hyper | artic | ve ! | i hery | AR ELLE | ; ; & | | ONSE | WAS AUTO | OPSY |
| AS UNDERLYING 20 G CAUSE OF DEATH MEDICAL EXAMINER) | њ. DESCRIBE HOW | / INJURY OCCUR | RED. (En | ter nature of injury in P | art I or Part | II of item 18.) | | | | |
| RY Month, Day, Year | While Not v | hile | PLACE C factory, | F INJURY (Home, form, street, office bldg., etc.) | 20f. (City | or town) | (Ca | ounty) | (5 | (State) |
| Philiple? | (1960 | ACICIONE PRINCIPIO PER PER HILL | M.D. | U. MATORY | M, from ADDRESS (SM | the causes are reet, city or town, a TAPSC | county) | e date | | obave |
| | If outside corporate limits, learnest lower. TAL (If for Art hospitol, grey between the corporate limits). TAL (If for Art hospitol, grey between the corporation of the corporation o | TAL (If for in hospital, give street oddress) 519 Latthew Ave First Edward 6 COLOR OR RACE 7. MARRIED NE WIDOWED NE WIDOWED NE WIDOWED NE WIDOWED NE Balto ON (Give kind of work done lob. KIND OF B Balto LWAP ence ER IN U. S. ARMED FORCES? 16. SOCIAL SE (If yes, give wor or dollar of service) WW I I ATH (Enler only one couse per line for (o). (a ATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO DUE TO ONLY, which Immediate the under OC (c) MER SIGNIFICANT CONDITIONS CONTRIBUTE AS UNDERLYING (c) While Not we of work of work done 19 of work of service) TY Month, Doy, Year 20d. INJURY OCC While Not we of work AS UNDERLYING (c) AS UNDERLYING (c) THE TO TO THE T | If outside carborate limits, write learnest lowest | ANNE Arundel MARYLAND (If outside corporate limits, write learnest lower law learnest lower learnest lower learnest lower learnest lower law learnest lower learnest lower learnest lower learnest lower law learnest lower learnest lower learnest lower law learnest lower learnest lower law learnest lower law learnest lower law learnest lower | ANNE Arundel MARYLAND OF STAT Carylan (If outlide corporate limits, write coret loyed) East to state the write coret loyed TAL (If for far hospital, give street oddress) ANNO Arundel MARYLAND STATE STATE ANNO C. LENGTH OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits), write C. LENGTH OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits), gred street oddress) J. STREET ADDRESS J. Matthew Ave S. 19 M | ANNE Arundel MARYLAND O STATE TAY IN 10 If outside corporate limits, write RU CITY OR TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CITY OR TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CITY OR TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If outside corporate) CORP OF TOWN (If outside corporate limits, write RU CORP OF TOWN (If ou | ANNE ATUNCE I MARYLAND 2 USUAL RESIDENCE (Where deceased lived it institution: Peridence of Shall Carry Land b. COUNTY AA If outside corporate limits, write c. LENGTH OF STAY IN 1b CCITY OR TOWN (If outside corporate limits, write RURAL and g SOB BY OND LYB TAL (If Ads/Minospinb). grid utreet oddress) TAL (If Ads/Minospinb). grid utreet oddress) First Edward Middle Edward Social Secret Minosack Format COUNTY AA Ave a Middle Edward G COLOR OR RACE MIDOWEDI DIVORCED B. DATE OF BIRTH MIDOWEDI DIVORCED B. DATE OF BIRTH MIDOWEDI DIVORCED B. DATE OF BIRTH MIDOWEDI BROWN (If outside corporate limits, write RURAL and g Mappinh Mappinh Middle ROSack Middle Formatic Middle Non Idia King life, even if restired MIDOWEDI DIVORCED B. DATE OF BIRTH MIDOWEDI BROWN (If outside corporate limits, write RURAL and g J A. STREET ADDRESS 519 Matthow Ave a Mignetic Middle Non Idia King life, even if restired Minority MIDOWEDI DIVORCED B. DATE OF BIRTH MIDOWEDI DIVORCED B. DATE OF BUSINESS OR INDUSTRY IT BIRTHPLACE (Stole or foreign country) MIDDWEDI DIVORCED B. DATE OF BUSINESS OR INDUSTRY IT BIRTHPLACE (Stole or foreign country) MIDOWEDI DIVORCED B. DATE OF BUSINESS OR INDUSTRY IT BIRTHPLACE (Stole or foreign country) MIDOWEDI DIVORCED B. DATE OF BUSINESS OR INDUSTRY IT BIRTHPLACE (Stole or foreign country) MIDOWEDI DIVORCED B. DATE OF BUSINESS OR INDUSTRY IT BIRTHPLACE (Stole or foreign country) MIDOWEDI DIVORCED B. DATE OF BUSINESS OR INDUSTRY MACHINES MADDEN NAME THE PROPINCE OF TALE OF BUSINESS OR INDUSTRY MACHINES MADDEN NAME THE PROPINCE OF TALE OF BUSINESS OR INDUSTRY Address Same ATM [Enter only or foreign country) MALE OF BUSINESS (Store), city or foreign country MIDOWED DIVORCED B. DATE OF TALE OF INJURY Home, form, 2004. (City or form) MIDOWED DIVORCED B. DATE OF TALE OF INJURY HOME, foreign country MIDOWED D. DESCRIBE HOW INJURY OCCURRED B. DATE OF INJURY HOME, | ANNE ATUNCE MARYLAND 2 USUAL RESIDENCE (Where deceased lived it institution: Residence before a STAN STATY Land b. COUNTY AA COUNTY | ANNE ATUNDE MARYLAND 2 USUAL RESIDENCE (Where deceased lived it institution. Peridence before admission) 5 ANT Larry Land 5 COUNTY AA 5 COUNTY AA |

ours after death. Page 4 and 2 should be filed with Pages 1 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22 may a gained by the haspital or attending physician.

OFUNAAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filter of FUNAAL DIRECTOR. After this certificate has been signed by the attendence of the burial-transit permit. Then please remayer carban papers. Pages the registrar priar to burial, cremation, or remayal, and in any event within 72 hours after death. TO FUND

VS A15 (4) 15M 10/57



| 1 | - | 3 P | LACE OF DEATH | 236(|) | | | 2. USUAL RESIDENCE | E (Where decay | and lived. If institu | | Dist. No dence bel | | nission) |
|---|--------|------------|--|--|-------------|----------------------------------|------------------|---|--------------------------|---|-----------|-----------------------|-----------------|----------------------------|
| 1 | | . 0 | COHNITY | rundel | | | ARYLAND | o slatrylar | | b. COUN | | | 010 00111 | marenty |
| - | 7 | | city or town a | (If outside corporate limits, wri rn) | e RURAL | Few min | | c. CITY OR TOWN | | | | nd give n | earest ta | own) |
| ř | è | а. О. | NAME OF HOSPI Ld Annapo | tal or institution of | of ft. | N. of R | dress) Ltchie | d. STREET ADDRES | s ?t # 4 | | | 1 | ON | ESIDENCE A FARM? |
| | | 3. N | IAME OF ECEASED Type or print) | Fii Sar | nuel | Hot | ard. | Lawson | 4. DATE OF DEATH | Mont | May | Day 1 | 3 1 | Year 19 60 |
| | | 5. SI | Male | 6. COLOR OR RACE White | 7. MARRI | _ | | | 1909 | 9. AGE (In years fail biribday) 51 yes. | Months | Doys | Hours | DER 24 HRS. |
| | | 10a. di | USUAL OCCUPATION MOST OF WORK | ION (Give kind of working life, even if retired) | dane 10b. I | A.A . C | | 11. BIRTHPLACE (SI | tate ar foreign | country) | 12. C | US. | | COUNTRY |
| | | 13. | FATHER'S NAME Wm. Howe | ard Lawson | | | | Jane Re | | n Fountai | in | | | |
| | | | WAS DECEASED EV | VER IN U. S. ARMED FO | | SOCIAL SECURITY | | Camily | | Address | | | | |
| | | | | ediate couse | | for (o), (b), and (c) Suicide | by C | ranide Poi | soning | | | INTE | Salat. | Shly |
| | | ICATIEN. | | HER SIGNIFICANT CON | | | | | | | VEN IN P | | 9. WAS PERFO | AUTOPSY DRMED2 NO TO |
| | | | 20g. External Ca Primary Case Co Cause of Death. | ONTRIBUTING 2 | | | | er noture of injury in Iskey and | | of item 18.) | | | | |
| | | MIDICAL | 9: 10 10 m | | - While | | factor | OF INJURY (Home, I y, street, office bldg., STOOT | orm, 20f. (City etc.) | Arnold | (0 | (ounty) | | (State) Md . |
| | a Maga | 1 1 | | hat I taak charge d from: Natural | | | | | — | nspectian 🗹 ndetermined | | | and | find tha |
| | (a) | | ACTUAL SIGNATURE | istaal Not | much | endud | | M.D. CHIEF MEDICA | L EXAMINER | 1 | | | DATE : | SIGNED |
| | | | EXAMINER'S NAME (Type) | Gustav Faub | ert M. | D. | | ASSISTANT MEDIC | | _ | | | 5/ | 13/60 |
| | | 220 | BURIAL CREMATIC REMOVAL (Specify BUT 121 | ON, 226. DATE THEREO |)F | 22c. NAME OF CE | | REMATORY Semetery | | timore | or county |) | (Stot | id. |
| | | _ | UNERAL DIRECTO | | 77 | ZADDRESS. | _10 | | EC'D BY REGIST | RAR 24b. REGI | | | | |



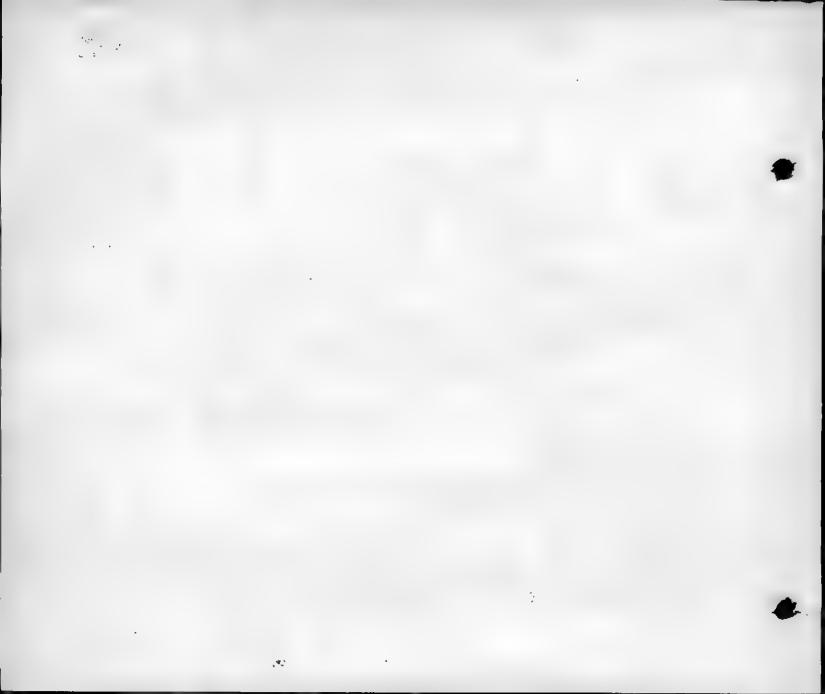
VS A15 (4) 15M 10/57

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| 900 | ector, i with | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5312 **CERTIFICATE OF DEATH** Reg. 05332

| | | | | | | T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1 | | | | | | |
|--------------|--|--------------------------------|-----------------|--|---------|--|--------------------------------|-------------------------------|--------------------------------|--------------------------------|------------------------|-------------------------------|
| 1 | PLACE OF DEATH | Arundel | | MARYLAN | II. | o. STATE | vlano | _ | ived. If institut b. COUNT | 1 - | e before adr Arunde | _ |
| r | | outside corporate limi | ts, write | c. LENGTH OF STAY IN | 1Ь | c. CITY OR TO | | | le limits, write | | | |
| П | Annap | | | | _ - | Ann | apol | is Box | z XX, R | FD 4 | | |
| | OR INSTITUTION | AL (If not in hospitol, g | | • | | d. STREET ADD | DRESS 3; | 20 | | an den. Abr | OI | RESIDENCE |
| L | Anne Aru | <u>ndel Gener</u> | al Ho | <u>spital</u> | | Box | DO , | RFD 4 | | | YES | □ NO 🔯 |
| 3. | NAME OF DECEASED (Type or print) | MARY M | si | Middle T | T**T) | Lost | | 4. DATE OF DEATH | Mav Mav | nnth () | Day | Yeor 19 60 |
| - | SEX | m - 4 200 v /m | 7. 44.00 | IED NEVER MARRIED | -1111 R | DATE OF BIRTH | | | AGE (In years | IF UNDER | 1 YEAR IF UI | NDER 24 HRS |
| Г | Female | White | WIDOWI | | | uly 17, | 1903 | | last by that y is | Months | Days Hou | |
| | At home | ing life, even if relired | done 10b. | KIND OF BUSINESS OR II | | Ma | rylai | nd | ntry) | | S.A. | HAT COUNTRY |
| 1: | . FATHER'S NAME | | | | | 14. MOTHER'S M | AIDEN N | AME | | | | |
| | Morris | Ferguson | | | | Ida M. | Beni | ner | | | | |
| | | | | SOCIAL SECURITY NO. | 7 INF | ORMANT | | | Ad | dress | | |
| 2 | (es, no. or unknown) No. | If yet, give war or dates at s | ervice) | | Coni | rad Lind | , Bo | x 520 I | XFD 4, . | Annapo | lis, N | id. |
| CENTERCATION | | in mediate DUF TO (co | 2 Pr DITIONS | nouno n | TUT N | Hial State PREMIND TO IN CENTER MOTOR TO IN | Cor app Personal Port | LENE Rene NAI DISEASE (| Cale Explication G | e | PE | AS AUTOPSY REORMED? |
| INCOLCAL | 20c. TIME OF INJUR Hour a.m. p. m. | Y Month, Day, Ye 19 | While | NJURY OCCURRED 204 k of work | factor | E OF INJURY (Ho ry, street, office b | me, form, ldg., etc] | 20f. (City o | r town) | (C | ounty) | (State) |
| 2 | actual SIGNATURE PHYSICIAN'S NAME (Type) | MATh. | 20 DL 1 | ed fram //- 8 (Q, , and that de // D 22c NAME OF CEMETER | eath o | 0.45 F3ng FR | 1124 Barle HNHL | M, fram ADDRESS (Stree LIN S | the causes et, city or town | and on the stole) MMA Area C | peli | he deceased above DATE SIGNED |
| | Burial (Specify) | 5/13/60 |) | Geln Have | n Ce | emetery | | Glen | Burnie | Md. | | |
| \vdash | . FUNERAL DIRECTOR | | 4210 | ADDRESS Belair Road | d. | 2 | 40. REC'E | BY REGISTRA | AR 24b. REG | ISTRAR'S SIG | | |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COMNTY MARYLAND CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) RURAL and give nearest/awn) lersve 1 d. NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? YES NO NAME OF DATE OF DEATH Middle Year DECEASED (Type or print) 196 Ē 9. AGE (In years last birthday) IF UNDER 17 EAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE DATE OF BIRTH MARRIED NEVER MARRIED Manths Days Haurs WIDOWED TX DIVORCED [yrs. 10a USUAL OCCUPATION (Give kind of work done of the during most of working life, eyen if retired) 12 CITIZEN OF WHAT COUNTRY? Own Home 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME attending physician within 113 Boone The 17 INFORMANT IN U. S. ARMED FORCES? M6. SOCIAL SECURITY NO please INTERVAL BETWEEN ONSET AND DEATH 1B. CAUSE OF DEATH [Enter only one course per line for (a) (b) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) **DUE TO** Canditians, if any, which gave rise to immediate 7 DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED? YES TI NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or Town) (County) (State) factory, street, office bldg., etc.) Haur a.m. While Not while at work at work p. m 19 (we) last 21 I certify that (I) (this haspital) attended the deceased fram... g say the deceased alive an and that death accurred at We'm the causes and an the date stated above 220. SIGNATUR PHYS MD. DIRECTOR _ 22d. ADDRESS 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a BJR AL CREMATION. 23d LOCATION (City, town, or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 23 DATE 1SM 9/59



05334

| | 536 | 2 | CERTIFI | CAIL | OF DEA | IH | | | | | |
|--|---|---------------|-------------------------------------|---------------------|--|-----------------------|-------------------------------|--------------------|---------------------------|------------------|------------------|
| 1. PLACE OF DEATH o. COUNTY Anne Arunde | 1 | | MANYA | 11 4 | STATE Maryland | _ ` | b. CC | nstitution: I | | ore admiss | ion} |
| b. CITY OR TOWN (F RURAL and give nec Crownsvill d. NAME OF HOSPITA | rest lown) | | LENGTH OF STAY IN JUNE 18 d | ays] | city or town | | porote limits, | write RURA | L and give ne $19 \times$ | e. IS RES | IDENCE |
| OR INSTITUTION Crownsvill | State Ho | spital | | | Inknown | | | | | | FARM? |
| 3. NAME OF DECEASED (Type or print) | | aymond | Middle | | Long | 4. DATE OF DEAT | | Month 5 | 2 | Ń | 19 60 |
| s sex Male | 6. COLOR OR RACE Negro | 7. MARRIED | NEVER MARRIED DIVORCED | | gust 26, | 1883 | 9 AGE (In last birth 76 | | INDER 1 YEA | Haurs Haurs | R 24 HRS Min |
| 10a. USUAL OCCUPATION during most of warking Unknown | N (Give kind of working life, even if retired | done 10b. KIP | ND OF BUSINESS OR | INDUSTRY | 11. BIRTHPLACE | | cauntry) | | U.S. | | OUNTRY |
| John A. Lo | ng | *** | | 14 | MOTHER'S MAII | DEN NAME | م | | | | |
| 1 | IN U. S. ARMED FOF yes, give wer or deles of I | service) | CIAL SECURITY NO. | 17. INFOR | mant pital Re | cords | | Address | | _ | |
| Conditions, if on gove rise to im couse (a), stoting Ill lying couse lost. | mediate DUE TO | C.B.S | . QSSOC. T | | | Genera. | ASE CONDITIO | Tenice ON GIVEN | 1 PART 1(a) | 19 WAS | AJTOPSY RMED? |
| PART II OTHI | UNDERLYING D CAJSE OF DEATH REDICAL EXAMINER) | 20b. DESCRI | BE HOW INJURY OC | CURRED. (Er | ter noture of inju | ry in Port I ar I | Part II of item | 18 } | | | № □ |
| 20c. TIME OF INJURY Hour o.m. | | | IRY OCCURRED 2 Naturabile — at work | PLACE (foctory, | OF INJURY (Home street, office bide | , form, 20f. (C | Lity or town) | | (County |) | (Stote |
| 21. I certify that saw the decease 22a SIGNATURE 22c. PHYSICIAN'S | - /- | 1) attended | the deceased f | | | MED. DIRECTOR | m the caus | | 19 <u>60,</u> the date | e stated | |
| NAME (Type) | 49 A A . T | v 3 . 73 | | | | | | | | | |
| 23a. BURIAL, CREMATION | | | eissman, l | | Crownsv | | ate Hos | | | rland . (Stot | |



05335

Day

U.S.A.

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO

> > (Stote)

22b DATE 152780

Days

(County)

arthur S. Kraus

1960 , that (1) (we) last

e. IS RESIDENCE

ON A FARM? YES NO IT

Year

19 60

YR A1S (4) 15M 9/59

. . 4

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 Item 2d, Fill GOEATH director Page 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission o. COUNTY filed o. STATE b. COUNTY death. funeral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR TOWN Uf outside corporate limits, write RURAL and give nearest town) RURAL and give-nearest town) D d NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? Annapolis. YES NO Y 3. NAME OF 4. DATE First Middle Month Year DECEASED (Type or print) DEATH FIRE 19 within 5. SEX 6 COLOR OR RACE 9. AGE (In years lost birthdoy) 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS. Months Dovs Hours WIDOWED DIVORCED [yes. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY during most of working life, even if/retired) 13. FATHER'S NAME 14 MOTHER'S MAINEN NAME hours 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address lif yes, give wor or dates of service) 2 ottending ease 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUÉ TO permit. Conditions, if ony, which gove rise to immediate DUE TO couse (a), stoting the underpup lying couse lost. burial-transit PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES I NO 20g. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING
CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) certificote (IF EITHER, NOTIFY MEDICAL EXAMINER) cremation, 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f (City or town) Day. Yeor 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc. O. RY. While Not while of work of work p. m. for 21. I certify that I attended the deceased fram, detached and that death accurred at 11 M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE should PHYSICIAN'S NAME (Type) 220 BURIAL CREMATION. 22b DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) REMOVAL (Specify) 0 23. FUNERAL DIRECTOR'S SIGNATURE 240 REC'D BY REGISTRAR 24Ь. REGISTRAR'S SIGNATURE **YS A15 (4)** 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5365 **CERTIFICATE OF DEATH** Reg. Dist. No. 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. COUNTY filod a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside carparate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) RURAL and give neatest town) pinor d. NAME OF HOSPITAL (If no) in hospital, give street oddress)
OR INSTITUTION e. IS RESIDENCE d. STREET ADDRESS ON A FARM? 3. NAME OF First Middle 4. DATE Month Day Year DECEASED (Type or print) DEATH 1960 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS MARRIED NEVER MARRIED last birthday) Months Days DIVORCED [WIDOWED [77] 10a. USUAL OCCUPATION [Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13 FATHER'S NAME MOTHER'S MAIDEN NAME 72 hours WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (If yes, give war or dates of service ending 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH <u>~</u> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate **DUE TO** cause (a), stating the underlying cause last. CATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO DE 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CERTI 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, form, 20f. (City or lown) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg, etc.) Hour a. p. While Not while of work of work p. m. 21. I certify that I attended the deceased from ...that I last saw the deceased _, and that death accurred at / M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) DREMOVAL (Specify) 2 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24o. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE

160



5313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 8 Rea. Dist. No. cremation 4 should PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. COUNTY o. STATE b. COUNTY MARYLAND b. CIDFOR TOWN III outside corporate limits, write RURAL c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and nive nectred lown) d. NAME OF HOSPITAL OF INSHTUTION (If not in hospitol, give street address) . IS RESIDENCE d. STREET ADDRESS 3 YES TI NO F NAME OF DATE Lost Month Day Yeor DECEASED Of (Type or print) DEATH 1960 ğ S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8 DATE OF SIRTH 9. AGE (In years IF UNDER 24 HRS. IF UNDER TYEAR lost birthday) Months Min. Hours WIDOWED [7] DIVORCED Yrs. 2 with 10g, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. B(STHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) å HOY 13. FATHER'S NAME 14. MOTHER'S MAIDEN MAME Pages 40 pode Page ! EVER IN U. S. ARMED FORCES? 36 SOCIAL SECURITY NO 17. INFORMANI Address File Give 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c). INTERVAL BETWEEN DNSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse lang M **DUE TO** (a), stating the underlying couse fost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED? NO. YES T 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of Item 18.) 200 EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | Child fell from pier into water 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, | 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year (County) (State) factory, street, office bldg , etc.) While Not while -Md. Bay Ridge of work of work ne r home p. m. 21. I certify that I took charge of the remains described above, held an Autopsy Inspection -Inquiry to the Chief I. DIRECTOR: I deoth resulted from: Natural causes Suicide [] Homicide . Undetermined cause DATE SIGNED **ACTUAL** CHIEF MEDICAL EXAMINER [7] SIGNATURE FUNERAL ASSISTANT MEDICAL EXAMINER [7] **EXAMINER'S** NAME (Type) DEPUTY MEDICAL EXAMINER 220 BURIAL CREMATION. 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. UOCATION (City, town, or county) (State) REMOVAL (Specify) 0 ADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24g, REC'D BY REGISTRAR Vs. A1SME(S) Circlian S. Krous 18'60 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 05340 CERTIFICATE OF DEATH 5366 eral director, be filed with 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside carparate limits, write c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) and give nearest Jawn) aNOUE d NAME OF HOSPITAL (If not in haspital, d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO zas DATE OF DEATH NAME OF Middle Month Year DECEASED 0 oges (Type or print) death. 19 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost biethday) Months Days Hours WIDOWED DIVORCED | pap≡rs. campl USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 12. CITIZEN OF WHAT COUNTRY? 2 during most of warking life, even if retired) DOMESTIC 13. FATHER'S NAME and pou physician g remove 17, INFORMANT S. ARMED FORCES? 16. SOCIAL SECURITY NO attending INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a). (b), and (c).] ONSET AND DEATH ā DEATH WAS CAUSED BY DUE TO ģ moval, permit. Canditions, if any, which been signed gave rise to immediate DUE TO cause (a), stating the undertransit lying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? burial YES TO NO TO 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) (State) Day, Year factory, street, office bida, etc.) MEDI Hour a. m White Nor while at wark ot wark p m. 21 I certify that (1) (this hospital) attended the deceased from Lithat (I) (we) last detached 19. 12 Cand that death accurred at 4 M. fram the causes and an the date stated above saw the deceased alive an AL DIRECTOR: 22a SIGNATURE 22b DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR 22c PHYS CIAN S 22d. ADDRESS TO FUNE 23c NAME OF CENTERY OF TREMATORY 25b. REGISTRAR'S SIGNATURE 25g. RFC'D BY REGISTRAR DATE MAY 25 '60 Cirthur S. Kraus VR A15 (4) 15M 9/59

RYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 5367 Rea, Dist. No. 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institutions Residence before admission) o. COUNTY **b** COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town! CCHCCK d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES A NO NAME OF 4. DATE First Middle Lost Month Doy Yeor OF DEATH (Type or print) 196 0 5. SEX MARRIED M NEVER MARRIED 9. AGE (In years FUNDER I YEAR IF UNDER 24 HRS. lost birthdoy) Months Davs Hours DIVORCED | WIDOWED | 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? Tobacco reenock 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME thid i Horeland 15 WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMAN /db CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) **DUE TO** Conditions, if ony, which gove rise to immediate DUE TO cause (a), stoling the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 CERTIFICATION WAS AUTOPSY PERFORMED? YES NO NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port It of item 18.) WEDICAL 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month. Doy, Year 20d. INJURY OCCURRED 20f (City or town) (Stole) (County) factory, street, office bldg., etc.) Hour a.m While Not while of work of work

22c. NAME OF CEMETERY OR CREMATORY

MTZION

21. I certify that I attended the deceased fram Calak

22b DATE THEREOF

1958, to Mily 8 , 1960, that I last saw the deceased

ADDRESS (Street, city or town, state)

22d. LOCATION (City, lown, or county)

24b REGISTRAR'S SIGNATURE Chilling S. Kines

LETHIAM MOY.

DATE SIGNED

(State)

and that death occurred at 1/2 ... M, from the causes and on the date stated above.

24a. REC'D BY REGISTRAR

MAY 1 2 '60

72 attending please within Š has been signed puo **burial-transit** this certificate 20 for use detached should 9

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION.

REMOVAL (Specify)

23. FUNERAL DIRECTOR'S SIGNATURE

I director, filed with

funeral

pluods

Poges

executed within 24 hours ofter death. Page

death certificate

PHYSICIAN: The law requires that the

VS A15 (4) 15M 9/5S



12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5368 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05338

Reg. Dist. No.

| 1. PLACE OF DEATH a. COUNTY Anne Arundel | MARYLAND | 2. USUAL RESIDENCE (WH | nere deceased lived. If institute b. COUNT | | efore admission) |
|--|---|--|--|------------------|-------------------------------------|
| b. CITY OR TOWN (if autoide corporate limits, write RURAL and give neores) found | c. LENGTH OF STAY IN 16 | | rutside carparate limits, write | RURAL ond give | nearest town) |
| Curtis Bay | 8 hours | Baltimor | re 13 | 31 | 101.4 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hasp | ital, give street address) | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM2 |
| In the Infirmary of Coast | Guard Yard | 3/415 Parl | clawn Avenue | | YES NO A |
| 3 NAME OF First DECEASED (Type or print) Arthur Mc Nally | Middle | Last | DATE MAY Mont | th. 196 | |
| 5. SEX 6. COLOR OR RACE 7- MARRIED | NEVER MARRIED [] 8. | DATE OF BIRTH | 9. AGE (In years | IFUNDER TYEA | R IF UNDER 24 HRS. |
| M MIDOMED | | 9/26/1900 | lost birthdoyl 59 yes. | Months Days | Hours Min. |
| 10c. USUAL OCCUPATION (Give kind of work done 10b, KI during most of working life, even if retired) Sheet Metal Vorker | ND OF BUSINESS OR INDUST | Baltimore | r foreign country) Md . | 12. CITIZEN | OF WHAT COUNTRY |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NA | AME | | |
| John McNally | | Catherine | Feehly | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. S (Yas, no, or unknown) 1 (If yas, gire wor or doles of service) | OCIAL SECURITY NO. 17. IF | FORMANT | Address | | |
| In Marine Corps 9 years | Mı | s. Mary Mc Ne | ally (wife) | | |
| 4 20 . 1 DUE TO | or (o), (b), and (c).] onary Occlusio | n | | INI ON | Sudden |
| gove rise to immediate couse (c), stating the underlying (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CO | NTRIBUTING TO DEATH BUT N | OT RELATED TO THE TERMIN | MALDISEASE CONDITION GIV | /EN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? YES NO 2 |
| | HOW INJURY OCCURRED. (E | nter noture of injury in Port | l ar Port II af item 78.) | | |
| Ö Hour q. m. While | Not while of work | CE OF INJURY (Home, form, ory, street, office bldg., etc.) | 20f. (City or town) | (County) | (Stole) |
| 21. I certify that I took charge of the r | emoins described obo | ve, held an Autopsy | , Inspection | , Inquiry 🛚 | , and find that |
| death resulted from: Natural couses | , Accident , Sui | cide, Homicide | , Undetermined | cause 🔲. | |
| SIGNATURE SUSTAN 1 Par | where and | _M.D. CHIEF MEDICAL EXA | | | DATE SIGNED |
| EXAMINER'S NAME (Type) Gustove H. Fs | ubert M.D. | ASSISTANT MEDICAL EX | /1 / | 60 | |
| | 22c. NAME OF CEMETERY OR Baltimore Nat | | 22d. LOCATION (City, town, Baltimore | | (Stote) |
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS Belair Road | 24o. REC'D | BY REGISTRAR 24b. REGI | STRAR'S SIGNAT | , |

TO MIY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death on is necessary, please executed certificate, writing the ward "pending" in pencil in them 18. Give Pages 1, 2, and 3 to the director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, DAOM VS. A15ME(5) 5M 9/55



MEDICAL EXAMINER'S CERTIFICATE OF DEATH cremotion 4 should PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) D. COUNTY o. STATE b. COUNTY arne Aru.del MARYLAND TV. a.o buriol, b. CITY OR TOWN III outside corporate limits, write RURAL c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armavolis 0 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -d. STREET ADDRESS Arte arundel General has ita South River Heights NAME OF First Middle DATE Month DECEASED (Type or print) DEATH May J Carl us tlund 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED N. DATE OF BIRTH 9. AGE He ween ş last birthdayt retoined Male . hite WIDOWED | DIVORCED | 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) en. during most of working life, even if retired) puo ofter 2, and Sweden puo none 2 none moy 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Carl J. Ostlund Sofia Anderson Poges ٧n 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address no Miss Eline Ostlund-Sister- same as # none PM3. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) buriol-transit **DUE TO** Conditions, if any, which gave rise to immediate cause Suo DUE TO (a) stating the underlying couse last. Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(d) ő 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) PRIMARY OF CONTRIBUTING DEATH. 3 should writing the ward MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Medical Poge 3 sh foctory, street, office bldg., etc.) Hour Not while D. M. of work of work p. m. 2). I certify that Ltook sharge of the remains described above, held an Autopsy ... Inspection X. 0 orwarded to the Chief FUNERAL DIRECTOR: death resulted (from:/ Natural causes A. Accident . Suicide . Homicide . Undetermined cause . SIGNATUR CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER **EXAMINER'S** DEPUTY MEDICAL EXAMINER ? NAME (Type) 22d. LOCATION (City, town, or couply) 220. BUR AL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) washin, ton, D.U. Cedar Hill Crematory Marr 25, 1960 ure nation 23. EUNERAL DIRECTOR'S SIGNATURE ADDRESS 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAY 2 7 '60

IA. II IS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C. Had & Heart

(County)

Reg. Dist. No.

a. e aru

Day

Days

USA

IFUNDER TYPAR

Months

e. IS RESIDENCE ON A FARM?

YES NO D

Year

IF UNDER 74 HRS.

Hours

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES 🗍

DATE SIGNED

(State)

Inquiry KD, and find that

NO D

(State)

19 60

Min.

ours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

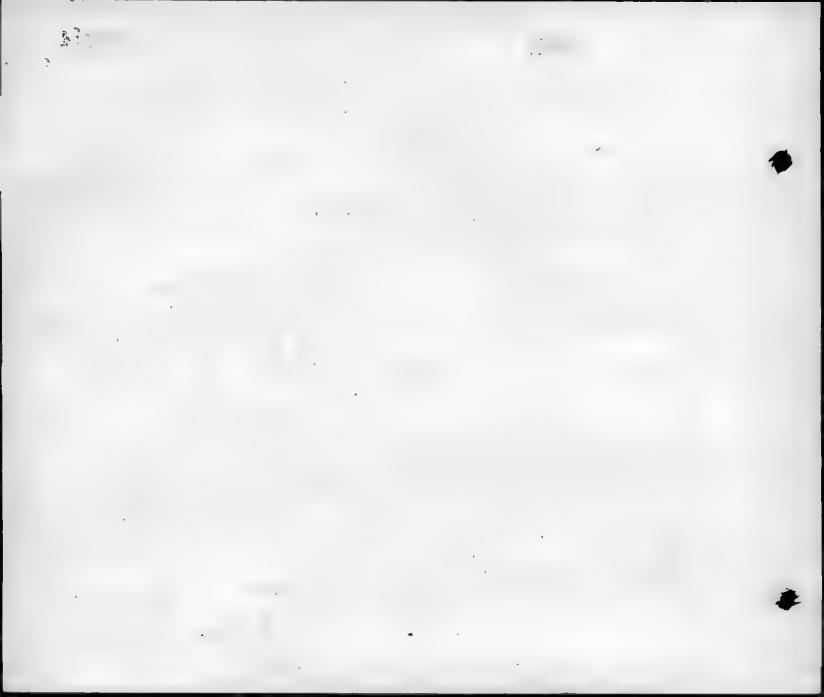
CERTIFICATE OF DEATH

05343

| | | 5369 | - | EKTIFICA | TIE OF D | EAIR | | | เกษอ | 10 | |
|---------------|---|---|---|-----------------|---|-------------------------------|--------------------------|-------------------------------|--|--------------------------------------|--------|
| 1 PL/ | ACE OF DEATH | e Arundel | | MARYLAND | 2, USUAL RESI | DENCE (Whe | ere deceased lived | . If institution b. COUNTY | Residence bef | | |
| ь | | autside carporate limits, wr arest tawn) | | H OF STAY IN 15 | c CITY OR I | | atside carporate li | mits, write RUI | | | |
| d. | OR INSTITUTION | AL (If not in hospitol, give st | reel oddress) | y m 10' 0 | d. STREET A | DDRESS | apolis B | vd. | | e. IS RESIDEN ON A FARI YES NO | M2_ |
| 000 | AME OF | First | | Middle | Los | | 4. DATE OF | Month | D | Day Year | 20 |
| 5 SE) | | 6 COLOR OR RACE 7 | AARRIED T NE | VER MARRIED | B. DATE OF BIRTI | H | 9. AC | | IF UNDER 1 YEA | 19 6 R IF UNDER 24 | |
| V | Ale | | OWED 🛴 | DIVORCED | Dec. 28. | 1869 | 90 | birthday) yrs | Manths Days | Haurs N | Ain. |
| 10a t | SUAL OCCUPATIO | N (Give kind of wark done ing life, even if relired) Ret. | _ | | | | | | | F WHAT COUN | ITRY? |
| | THER'S NAME | r Ket. | Constr | uction | New 14. MOTHER'S | York S | | | U. | S. | |
| | Michael | Owens | | | | Bride | 4 | :h | | | |
| | | R IN U. S. ARMED FORCES? If yes, give wor or dates of service) | 16. SOCIAL SE | | NFORMANT James | | _ | Addre Same | 22 | | |
| - , | Canditians, if or gave rise to in cause (a), stating t lying cause last, | n mediole (| | arte | hronic | cois | your | idiot | Visla | <u> </u> | |
| CERTIFICATION | PART II OTH | ER SIGNIFICANT CONDITIC | ONS CONTRIBUT | ING TO DEATH BU | T NOT RELATED TO |) THE TERMIN | NAL DISEASE CON | DITION GIVE | N IN PART 1(a) | PERFORMET YES NO | D? |
| | OG ACCIDENT WA OR CONTRIBUTING FEITHER, NOTIFY | S UNDERLYING 20b. CAUSE OF DEATH MEDICAL EXAMINER) | DESCRIBE HOW | / INJURY OCCURR | ED, (Enter nature a | f injury in P | ort I ar Port II af | item 1B.) | | | |
| MEDICAL | C. TIME OF INJURY Hour a.m. p. m. | 10 W | Od. INJURY OCC /hile Nat w wark at wo | | LACE OF INJURY (octory, street, office | Home, form, a bldg., etc.) | 20f. (City ar ta | ~n) | {County | (5 | State) |
| S | aw the deceos | t (1) (this hospital) at | | eceased fram. | 7/ | 19. 19.30/ | 55.to 22 M, from the | | | | ave. |
| | 2a S GNATURE | orus g | gla | 11 | M.D. ATTENDIN | | D STA | Ys. 🗌 🗎 | lay 13, | 1960 SIG | GNED |
| 2 | 2c. PHYSICIAN'S NAME (Type) | Louis J. Gla | ss | | 320 320 | Patap | sco Ave | . Balt | 0. 25, | Md. | |
| 9 | REMOVAL (Specify) | N, 23b. DATE THEREOF | 0 | ME OF CEMETERY | | | 23d LOCATION | | caunty) | (State) | |
| | HERAL DIRECTOR: | SIGNATURE | ADDI | | | 25a. REC'D | Woodbrid BY REGISTRAR | 256 REGIST | W Jerse TRAR'S SIGNATI Thuy I, The | URE | |
| 110 | mary | 70mc 400] | L Ku tchi | e Howy | Bal to .25. | DAIL N | N 1 8 '60 | | | | |

TO HOSP AL OR ATTENDING MIYSICIAN: The law requires that the death meritificate be executed within 24 than may be reduised by the haspital or attending physician.

TO MUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled. To page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and the State Board of Health prior to burial, cremation, or remaval, and in any event, within 72-bours after death VR A15 (4) 15M 9/59



| CERTIFICATE | OF DEATH |
|-------------|----------|
| CERTIFICATE | OI DEAIL |

05344

| 5315 | CERTIFICAT | E OF DEATH | | Reg. Dist. | No. |
|---|--|---|--------------------------|-----------------------|--|
| 1. PLACE OF DEATH O. COUNTY a. Coun | tes MARYLAND 2 | USUAL RESIDENCE (Whee o. STATE) | re diceased lived., If i | nstitution: Residence | before-odmission) |
| Charles of give regress fown) | LENGTH OF STAY IN 16 | c. CITY/OR TOWN (II/ou | tside carperate limits, | write BURAL and giv | |
| or Institution of Comments of the Comments of | Street 1 | OON, NICO | hungte | M | e. IS RESIDENCE ON A FARM? YES NO X |
| 3. NAME OF DECEASED (Type or print) | il Middle Pa | arker | 4. DATE OF DEATH | Month | Day Year 1960 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED WIDOWED | Za reaction marketiness. | DATE OF BIRTH 4-24-18 | 9. AGE (In | | YEAR IF UNDER 24 HRS |
| 100. USUAL OCCUPATION (Give kind of work done 10b. KIN during mast of working life, even if retized) | ID OF BUSINESS OR INDUSTRY | M. B) RIMPLACE (State of | r fareign country) | 12. CINZ | EN OF WHAT COUNTR |
| John Mc Bowa | us di | 14. MOTHER'S MAIDEN NA | Mary | Joh | uson |
| 15. WAS DECEASED EVER IN/U. S. ARMED FORCES? 16 SOC | CIAL SECURITY NO. 17. INFO | mes pa | ikerio | 6Willa | sh. St. |
| 18. CAUSE OF DEATH {Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) COL | or (0). (b). and (c).) / ngestive Heart | Failure | | | INTERVAL BETWEEN ONSET AND DEATH |
| gave rise to immediate | pertensive Care | dio Vascular | Disease | | |
| couse (a), stating the <u>under-lying couse last.</u> Column (c) | CONTRACT TO SCATIL BUT NO | T OFFICE TO THE TERMINA | A DECEMBER | | A PARAMETER AND A PARAMETER AN |
| PART II. OTHER SIGNIFICANT CONDITIONS CON 206. ACCIDENT WAS UNDERLYING OR CONTRIBUTING COR | | | | | PERFORMED? YES NO |
| | BE HOW INJURY OCCURRED (| Enter nature of injury in Po | nt I ar Part II af ilem | 18 } | |
| A Hour e. m. While | RY OCCURRED 20s. PLACE foctor of work | OF INJURY (Hame, form, y, street, office bldg., etc.) | 20f. {City or town} | (Co | unty} (State |
| 21. I certify that I attended the deceased | | | | | |
| olive on May 17, 19 60 | and that death a | | M, fram the cau | | date stated abov |
| SIGNATURE In There' A. | Skinson J.M.C | 37_Calve | , , , | | lay 18, 196 |
| PHYSICIAN'S Dr. Theodore H. J | Johnson, Jr. | Amapoli | is, Murylar | ıd | ** to see on the see the six on the see on see on |
| BUNGE 5-20-60 | 2c. HAME OF CEMETERY ORX | REMATORY : | 12d. LOCATION (City. | Gale | MI (State) |
| 23) FUNERAL DIRECTOR'S SIGNATURE | ADDRESS ALCCE | DATEAY | 1 | REGISTRAR'S SIGN | • |

TO HOSFIJAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competerly film, in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pagers 1 and 2 should be file!! with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A1S (4) 1SM 9/S5

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| Ì | |
|---|-----------------------|
| | |
| | 1. PLACE OF DEATH |
| | a. COUNTY A |
| | - Amne Aku- |
| | b. CITY OR TOWN (IF a |
| | RURAL and give negli |
| | 110 11. 1160 |

E270

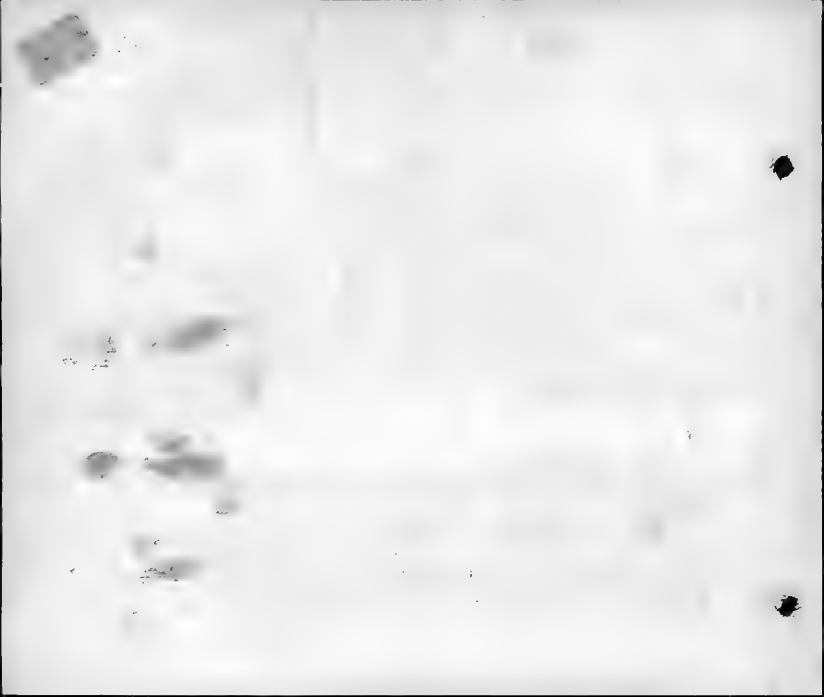
CERTIFICATE OF DEATH

| 001 | | | Reg. Dist. No. |
|---|--|--|---|
| 1. PLACE OF DEATH O. COUNTY | MARYLAND | 2 USUAL RESIDENCE (Where deceased live a. STATE | b. COUNTY |
| b. CITY OR TOWN (If outside corporat RURAL and give regrest lawn) | te limits, write c. LENGTH OF STAY IN 16 | c. CITY OF TOWN (If autside corporate | limits, write RURAL and give nearest lown) |
| Milletsville | 25 years. | X Millersy, The (RFD) |) E /vator |
| or Institution Jumper Hole 101 | ital, give street oddress) Elvator | Box 302 - Turber | Halo Road ON A FARM? YES NO D |
| 3. NAME OF DECEASED | First Middle | Lost 4. DATE OF | Month Day Year |
| (Type or print) Char | les F. | TeTet DEATH | May 24, 1960 |
| 5. SEX 6. COLOR OR R | | B DATE OF BIRTH | AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS ast birtheay) Manths Days Hours Min |
| Male Whit | wark done 10b KIND OF BUSINESS OR INDUS | STRY 11 BIRTHPLACE (Stole or foreign count) | 66 yrs |
| during most of working life, even if n | etired) | STRY II BIRTHPLACE (State or foreign country II) | 12 CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME | - Scal 18 | 14 MOTHER'S MARGEN NAME | n (1 · J · π - |
| James F | Dotat+ | Agnes Lewis | |
| 15. WAS DECEASED EVER IN U. S. ARMEE | | NFORMANT | Address # |
| No | / Unknown MI | ts. Mabel L. Petett | Danehs"2 |
| 18. CAUSE OF DEATH [Enter only of PART 1 DEATH WAS CAUSED | ane cause per line far (a), (b), and (c) | Onlan | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAL | USE (o) C/(YU/V/ | C 0 /0 /y | 6 MOS. |
| Conditions, if any, which | UE TO | | |
| gave rise to immediate | (b) UE TO | | |
| tying cause lost. | (c) | | |
| PART II. OTHER SIGNIFICANT 20g ACCIDENT WAS UNDERLYING I OR CONTRIBUTING I CAUSE OF DI (IF EITHER, NOTIFY MEDICAL EXAMIN | CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CO | ONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? YES NO |
| | 205. DESCRIBE HOW INJURY OCCURRENT NERS | D. (Enter nature of injury in Part 1 or Part 11 o | f item 18) |
| 20c. TIME OF INJURY Month, Day, Hour a. m. p. m. | 7, Year 20d. INJURY OCCURRED 20e. PU While Not while of work for | ACE OF INJURY (Home, form, 20f. (City or tory, street, office bldg., etc.) | (County) (State) |
| 21. I certify that I attended | the deceased from 1144 2 | , 1960, 10 May 21 | 4., 19.60 that I last saw the deceased |
| alive on May 2 | 19 60 , and that death | accurred at 2: 1- M. from th | ne causes and an the date stated above. |
| ACTUAL SIGNATURE | Mariala Mis | MD. ROACO | -city or layon, state) DATE SIGNED CE HULL 5-25-66 |
| PHYSICIAN'S C. R. Mac) | loneld, 14.D. | Extense un | ie Med |
| 220. BURIAL CREMATION 226. DATE TO REMOVAL (Specify) 25# Ma | HEREOF 220 NAME OF CEMETERY O | | (City, town, ar county) (State) |
| 23. EUNERSI DIRECTOR'S SIGNATURE | do Clan Bultie) | MO , 240. REC'D BY REGISTRAR | 4 = |

n by the funeral director, and 2 shauld be filed with TO HOWITH OR ATTENDING PHYSICIAN: The law remuires that the demth certificate be executed within 24 haurs after death. Mage 4 may the lained by the hospital ar attending physicion.

O FUN — I DIRECTOR: After this certificate has been signed by the attending physician and campletely fill, page 3 should be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 the registrar priar to burial, crematian, ar remaval, and in any event within 72 haurs after death. TO FUN

VS A15 (4) 15M 10/57



VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05346

| , | PLACE OF DEATH o. COUNTY Anne Arundel | | MARYLA | AND | 2. USUAL RESIDEN o. STATE | , | b. COUNTY | | | e admiss an) |
|---|--|-------------------------------|-------------------------|------------|---|----------------------|-----------------------|------------|------------|----------------------|
| | b CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 1b | | | | Maryland Queen Annes c CITY OR TOWN (If outside carporate timits, write RURAL and give nearest fown) | | | | | |
| | RURAL and give nearest town) Crownsville | Chester | | | | 17x | P 15 1 | | | |
| | d. NAME OF HOSPITAL (If not in hospital, gi | ve street od | 13 days | | d. STREET ADDR | RESS | | | e | . IS RESIDENCE |
| | Crownsville State | Hoani | +61 | | Unknown | | | | | ON A FARM? YES NO NO |
| | 3. NAME OF Firs | | Middle | U | Last | 4. DATE | Mor | - 4L | Day | |
| | DECEASED | lter | Production | | Polk | OF DEATH | | | 17 | |
| | | | D NEVER MARRIED | ₽ 8 | DATE OF BIRTH | | 9. AGE (In years | | (| IF UNDER 24 HRS |
| | | WIDOWED | | | June 14. | 1896 | last birthdoy) 63 yrs | Months | Days | Haurs Min. |
| | 10a USJAL OCCUPATION (Give kind of work d | one 10b KII | ND OF BUSINESS OR | INDUST | | (State or foreign of | | 12. CIT | IZEN OF | WHAT COUNTRY? |
| | Ovster Shucker | | | | Pennsy | lvania | | | U.S | S.A. |
| 1 | 13. FATHER'S NAME | | | | 14. MOTHER'S MA | | | | | |
| 1. | Unknown | | | | Unknov | V23 | | | | |
| | IS WAS DECEASED EVER IN U. S. ARMED FORCE | | CIAL SECURITY NO. | 17. INF | ORMANT | | Add | ress | | |
| -4 | Yes (If yes, give wor or dates of set | | 4-01-0844 | I | ospital F | Records | | | | |
| | 18. CAUSE OF DEATH [Enter only one cou | se per line | for (a), (b), and (c) } | | | | | | INTER | RVAL BETWEEN |
| ì | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o). | Ce | erebral Hen | orr | hage | | | | ONSE | T AND DEATH |
| | LALL 2 DUE TO | | | | | | | - | | |
| | Conditions, if ony which) | Arter | rioscleroti | ic H | ypertensi. | ve Cardio | vascular | Dise | ase | |
| | gave rise to immediate cause (a), stating the under- | | · · · · | | *_* | | | | | |
| | lying couse lost. (c) | Via cova led Adming the Onder | | | | | | | | |
| | PART II. OTHER SIGNIFICANT COND | ITIONS COL | NTRIBUTING TO DEAT | H BUT N | OT RELATED TO THE | ETERMINAL DISEA | E CONDITION GIV | EN IN PAR | (T 1(o) 19 | WAS AUTOPSY |
| | CAI | | | | | | | | | PERFORMED? |
| | PART II. OTHER SIGNIFICANT COND OR CONTRIBUTING OR CONTRIBUTING OR CONTRIBUTING OR CONTRIBUTING OR CAUSE OF DEATH OR FEITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRI | BE HOW INJURY OCC | URRED. | (Enter nature of inj | ury in Part I or Po | rt II of item 1B) | | | |
| | | | | | | | | | | |
| | 29c. TIME OF INJURY Manth, Doy, Year | | | De. PLAC | E OF INJURY (Homory, street, office bld | e, form, 20f (Cit | y ar town) | | County) | (State) |
| | Haur are | ot work [| Hot wiffle | | ny, ander, orașe bie | 9.7 | _ | _ ` | | |
| | 27 I certify that (I) (this haspital) | attended | the deceased fr | am | 5/4/ | 12,60 to | 5/17 | 1960 | O the | at (I) (we) last |
| | saw the deceased alive an5/ | | 19 60 , and th | | | A.M. from | the causes an | id an the | e date | stated abave |
| | 220 SIGNATURE | -1 1 | 1 | | | | | | | 22h. DATE |
| | 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 1 4 2 | (1) 1- | M | D PHYS | MED DIRECTOR | STAFF PHYS | | 1 | 5/17/60 ED |
| 22c. PHYSICIAN'S NAME (TYPE) Hildegard Heard Reissman, N. D. Crownsville State Hospital, Maryland | | | | | | | | 3 | | |
| | Hildegard Hear | rd Rei | ssman, M. | D. | Crowns | ville Sta | te Hospi | tal, | Mary | Lana |
| | 230 BURIAL, CREMATION, 23b, DATE THEREOF | | HAME OF CEMET | RY OR | CREMATORY | 23d. LOCA | JION (City tawn, | ar county) | | (Stole) |
| | Kemoval 9/2/6 | 0 4 | Universe | tu | Of Mide | | Sallemo | re- | /// | kl. |
| | 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS 68 4 | 1340 | CHECK ! | REC'D BY REGIS | TRAR 25b REG | STRAR'S SI | GNATURE | |
| | William Flese | H | annag | 1-0 | Mo | H 6 '60 | On Thur | 2. Ken | 44 | |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5316

CERTIFICATE OF DEATH

05347

| | | Reg. Dist. No. |
|---|--|---|
| | 1. PLACE OF DEATH o. COUNTY | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) |
| | Anne Arundel MARYLAND | o. STATE Maryland b. COUNTY Anne Arundel |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) |
| | Annapolis | Annapolis |
| - | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| | Anne Arundel General Hospital | 19 Jefferson Place YES NO 🖪 |
| | 3. NAME OF DECEASED (Type or print) OFAMES | PORTER Month Doy Year DEATH MRY 4 1960 |
| | 5. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS |
| | Male White WIDOWED DIVORCED | January 301913 lost birthdoy) Months Days Hours Min. |
| | 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU- during most of working life, even if retired) | JSTRY 11. BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY |
| | AIR CONDITION | Maryland U.S. |
| | 13 FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| 1 | OAMES L PORTER | STELLA MITERS |
| | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. | INFORMANT Address |
| | / - / - / | INNA MI, PORTER (2) |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | INTERVAL BETWEEN ONSET AND/DEATH |
| | PART I. DEATH WAS CAUSED BY MAN DICK TREEL | need hencertage 33 theren |
| | PUE TO | |
| | Canditions, if any, which) (b) | |
| | gave rise to immediate couse (o), stoling the <u>under-</u> | |
| | lying couse last.) (c) | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES \(\sum \ NO \sum \) |
| | 706 ACCIDENT WAS UNDERLYING 206 DESCRIBE HOW INJURY OCCURR OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | ED (Enter noture of injury in Port I or Port II of item 18.) |
| | | LACE OF INJURY (Home, form, 20f. (City or town) (County) (Slote) |
| | | octory, street, office bldg., etc.) |
| | \$ / 2 | 19-4, ta 5/4, 19-4, that I last saw the deceased |
| | 21. I certify that I ettended the deceased fram 2/3 | h accurred at 2220 M, from the causes and an the date stated above |
| | dive on that deal | ADDRESS (Street, city or town, stole) ADDRESS (Street, city or town, stole) |
| | SIGNATURE Lecleary N & Reker | M.D. 121 Cathedral St., 5/4/60 |
| | PHYSICIAN'S Richard N. PEELER | Annapolis, Maryland |
| | 270. BURIAL, CREMATION, 226. DATE THEREOF 270 NAME OF CEMETERY | DR CREMATORY ' 22d. LOGATION (City, town, or county) (State) |
| | Bures May 6-1960 Helerist | namoral Amapolio Mel |
| | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 240 REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE |
| | from 11. Vuyen and Commey | DATRIAY 6 '60 O 11 - 0 4 |

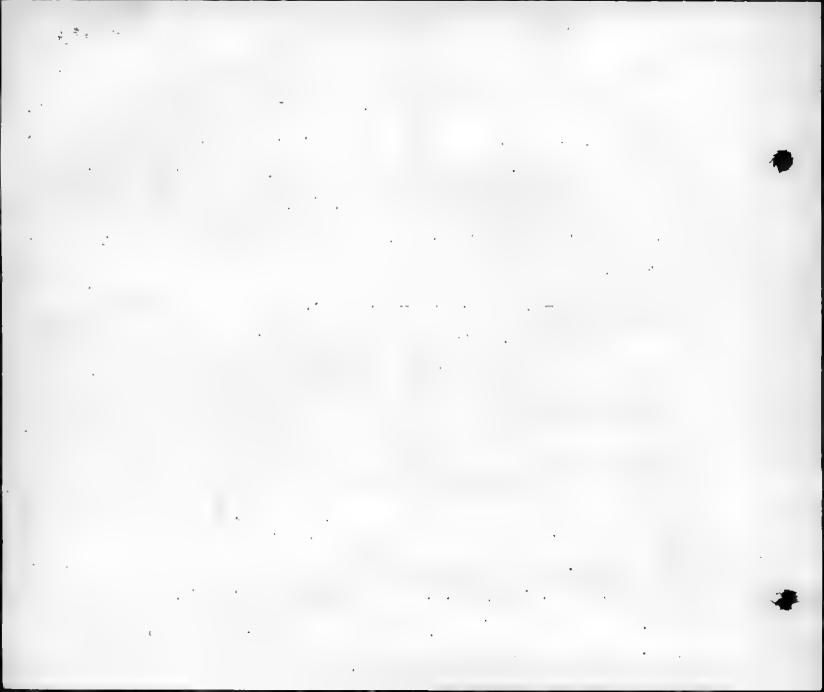
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*--- IDA

VS A15 (4) ISM 9/S8

1009 Phillip Drive, Glen Burnie, Md. e. IS RESIDENCE ON A FARM? YES NO TH 1960 IF UNDER 1 YEAR IF UNDER 24 HRS Manths 12. CITIZEN OF WHAT COUNTRY? United States Same as above (wife) INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO F (County) (State) AY 25 , 1960, that I last saw the deceased 19 60, and that death accurred at 11. 40A M, from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, state) 22d LOCATION (City, tawn, or county) (State) Glen Burnie. Maryland 24b REGISTRAR'S SIGNATURE Kirkley arthur S. Kraus DATE MAY 3 1 '60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. director PLACE OF DEATH. 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admissible o. COUNTY b. COUNTY filed erol CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR-TOWN (If outside corporate limits, write RURAL and give negrest fown) RERAL and give negrest town). shamld d. NAME OF HOSPITAL (If not in hospito), give street address STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NAME OF 4. DATE DECEASED 60 Filler (Type or print) DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years lost birMday) Months Doys Haurs WIDOWED comple 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (State or foreign country) during most of working life, even if refired) guq 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 5 physici IN U. S. ARMED FORCES? INFORMAN 16. SOCIAL SECURITY NO dates of service) attending INTERVAL BETWEEN
ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c), ₻ I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o), the DUE TO Conditions, if ony, which gned gove rise to immediate DUE TO couse (a), stating the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Surial-NO 🗌 20a, ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Doy, 20e PLACE OF INJURY (Home, farm, 20f. (City or town) Year 20d. INJURY OCCURRED (State) (County) factory, street, office bldg., etc.) 9 Hour o.m. While Not while 19 of work of work p. m. 21. I certify that I attended the deceased from Source 1960 that I last saw the deceased and that death accurred at PM, from the causes and an the date stated abave. alive on 28 ADDRESS (Street, city or town, stote) DATE SIGNED DIRECT ACTUAL SIGNATURE P PHYSICIAN'S TO FUNERAL NAME (Type) DATE THEREOF BUR AL, CREMATION, 22d. LOCATION (City, town, or county) 22c. NAME OPICEMETERY OR CREMATORY (Stote) pode REMOVAL (Specify) 24b REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240, REC'D BY REGISTRAR VS A15 (4) arthur & Kines DATE 15M 9/5B



05350

5318

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | DOTO | | | | | Keş | J. DIST. No. | |
|---------------|--------------------------------------|--|----------------------------|----------------|-----------------------------------|---------------------|--------------------------------------|---------------------|---------------------------|
| 1. | PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Who | | | sidence befare adm | issian) |
| L | v. cooliii | Anne Arund | iel M | ARYLAND | Maryla | and | b. COUNTY Am | ne Arunde. | L |
| | b. CITY OR TOWN (I RURAL and give no | f outside carparate limits, w | rite c. LENGTH OF S | TAY IN 15 | c. CITY OR TOWN (If at | ilside carporate li | mits, write RURAL | and give nearest to | wn) |
| L | Annap | and the second s | | | /O Anna | polis | | | |
| Г | d. NAME OF HOSPIT | AL (li not in hospitol, give in Dead on ari | street oddress) | | d STREET ADDRESS | | | | ESIDENCE A FARM? |
| Aı | nne Arunde | l General Hos | spit aí | | 22 Locus | st Ave. | | | NOK |
| 3. | NAME OF DECEASED | First | Mi | ddle | Lost | 4. DATE OF | Month | Doy | Yeor |
| | (Type or print) | John | 1 | | RAWLINGS | DEATH | May | 20 | 19 60 |
| 5. | SEX | | MARRIED NEVER MA | ARRIED 🔲 | B. DATE OF BIRTH | l ou | | NDER I YEAR IF UN | - |
| | Male | White w | DOWED DIVO | RCED 🔲 | March 27, 189 | 91 6 | | oths Days Hour | s Min. |
| 10 | o. USUAL OCCUPATIO | ON (Give kind of work dane ing life, even if retired) | 106. KIND OF BUSINES | SS OR INDUS | TRY 11. BIRTHPLACE (State of | ir foreign country | 13 | 2. CITIZEN OF WHA | AT COUNTRY |
| 0 | 12 4 / | apoles Dure | Wilcom | un | Maryla | nd | | U.S. | |
| 13. | FATHER'S NAME | 1,40 | 7 1 | | 14 MOTHER'S MAIDEN N | AME | | | |
| | Dames | el T. VI | awten | 90 | Umna | M. | JALLE | cly | |
| 15 | WAS DECEASED EVE | R IN U. S. ARMED FORCES | 7 16. SOCIAL SECURITY | NO. 17. J | NFORMANT P | 17 | Address | (1/2) | |
| L | YES 1 | 1917-1919 | | 6 | ignes . Oi | Tono | tengo | V (%) | |
| Г | 18. CAUSE OF DEA | TH [Enter anly one cause | per line for (a), (b), and | (c)] | 1 2 | 4.6 | | INTERVAL | BETWEEN |
| | PART I. DEA | TH WAS CAUSED BY: IMMEDIATE CAUSE (a) | 3 , , A. | MILLIAN | Tandin I | Wall | Mer- | ONSET AN | |
| | 20 | # DUE TO | | | | | | | MAX.80 |
| | Conditions, if o | ny, which l | | 1 | | r | | | |
| | gave rise to in | nmediate (| | | | | | | |
| | lying couse lost. | the under- | | | | | | | |
| z | | | ONS CONTRIBUTING TO | DEATH BUT | NOT RELATED TO THE TERMIN | IAL DISEASE CON | IDITION GIVEN IN | 1 PART 1(a) 19. WAS | SAUTOPSY |
| CERTIFICATION | | | | | | | | | ORMED? |
| Ę | 200. ACCIDENT WA | S LINDERLYING [] 206 | DESCRIBE HOW INJUR | Y OCCURRE | (Enter nature of injury in P | art I ar Part II of | item 18.) | | |
| 3 | OR CONTRIBUTING | S UNDERLYING (206 CAUSE OF DEATH MEDICAL EXAMINER) | | | | | | | |
| 3 | | | 20d. INJURY OCCURRED | 20e. PL/ | CE OF INJURY (Hame, form, | 20f. (City or to | wn) | (Caunty) | (Slote) |
| MEDICAL | Havr e.m. | | While Not while at work | | dary, street, affice bldg., etc.) | | | | |
| 3 | | | | | 1-60 . May | r 20 | · · · · 60 · · | | |
| | | at I attended the de | | | , 1960 , to Ma: | | | | |
| | alive on May | -473 | 1960 , and t | hat death | occurred a 10:45A | | causes and (tity or town, state) | | ited abave DATE SIGNED |
| | ACTUAL / | 1.1 + 1/21 | 7.11. | | | edral St | | 5/2 | 0/60 |
| | SIGNATURE | LPV N LLCO | CEVIVI | | M DBattle | Edrat Do | • 2 | | 02.00 |
| | PHYSICIAN'S | John L. Heder | ran | | Annapoli: | a Marvil | and | 14 | |
| = | | | | CÉLIERE DV. CO | | | | | |
| 1 | REMOVAL (Specify) | | 22c NAME OF | LEMEIERY O | CREMATORY | ZZa LOCATION | City, tawn, or cau | inty] ' (Si | 210 |
| 22 | FUNERAL DIRECTOR | 12 27 27 27 27 | ADDRESS | UNI V | VERETH . | CANN. | 245 REGISTRAR | PS SIGNATURE | MUCK |
| 13 | Service Director | M. Jaylor | Sino Com | apo | les MARC 240. REC'D | AY 25 60 | | us S. Haus | |
| | 110000 | 1, 100 | | | DATE | | | | |

TO HOSP CAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2, agous after death. Page 4 may be lained by the hispital or attending physician.

TO FUNKAL DIRECTOR: After this certificate has been signed by the attending physician and commetely first which the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with, the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/55



fille,

d=th certificate

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physician has been

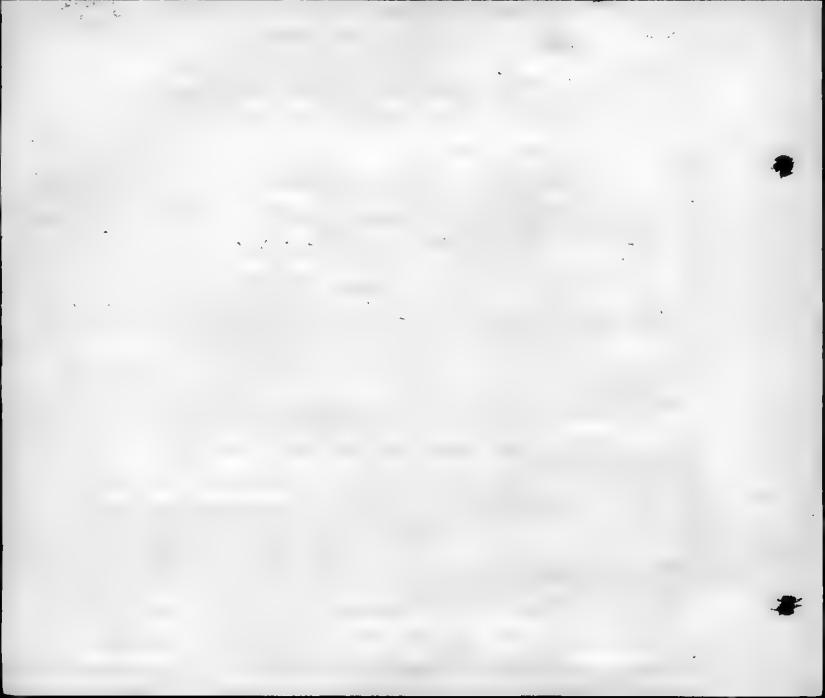
Afler

FUNERAL DIRECTOR:

AL OR



| ¥1 -, | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | |
|--|--|---|
| 1. 3/ | 1 tem 9, telephon coll. Ison Foreral Home 7/12/60 1) 5374 CERTIFICATE OF DEATH Reg. Dist. No. | 352 |
| I director | 1. PLACE OF DEATH O. COUNTY 2. USUAL RESIDENCE (Where deceased lived. Il institution: Residence below. STATE) b. COUNTY MARYLAND | re admission) |
| e funeral could be f | b. CITY OR TOWN (II outside corporate limits, write RURAL and give new | |
| oby th d 2 sh | 219 Bolivar AVE 219. Bolivar AVE | e. IS RESIDENCE ON A FARM? YES NO Z |
| es – se | 3. NAME OF DECEASED (Type or print) Alice VILGINIA REYNOLDS OF DEATH 5-13 | - 1960 |
| rs. Page | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 3. 8. DATE OF BIRTH 9. AGE (In yeons lost birthday) Months Days FEMALE COLOR OR RACE 7. MARRIED DIVORCED 3-1-1874.86 95 yrs. Months Days | Hours Min. |
| e execure and camp can pape ir death. | 100. USUAL OCCUPATION (Give kind of work done during most of working lile, even if returnd) 105. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or loreign country) 11. BIRTHPLACE (Stole or loreign country) 12. CITIZEN OF COUNTRY 12. CITIZEN OF COUNTRY 13. BIRTHPLACE (Stole or loreign country) | F WHAT COUNTRY |
| physician ar move carba hours after | 13. FATHER'S NAME Sandy Scott 14. MOTHER'S MAIDEN NAME Salle | |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address NONE Senevieve TULNES | ame_ |
| ottending of within 72 | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: | ERVAL BETWEEN SET AND DEATH |
| by the 1. Ther y even! | DUE TO Conditions, if ony, which) (b) | |
| equires in. signed it permi | gave rise to immediate code (a), stating the under lying couse lost. | |
| physicio as been ial-trans aval, or | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 9. WAS AUTOPSY PERFORMED? YES NO P |
| ending ficate h ficate h the bur or rem | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II al item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| his certi | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. P. m. 19 Of work of work of work | (State) |
| hospito After the hed for riol, cre | 21. I certify that I attended the deceased from III and III, 1901, to III III, 1801, that I last so alive an William III and the deceased from III a | |
| by the control of the | ACTUAL ADDRESS (Street, city or tow); Thate | DATE SIGNED |
| Tor price | PHYSICIAN'S THUS INVOCABLE | |
| oy to the same of | 220. BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, Jown, or county) | (State) |
| VS A15 (4) | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATUR | RE TRICE |
| 15M 9/SS | Chroy O. Wish Brankley MC DATE MAY 25 60 Citien & M. | 114 |



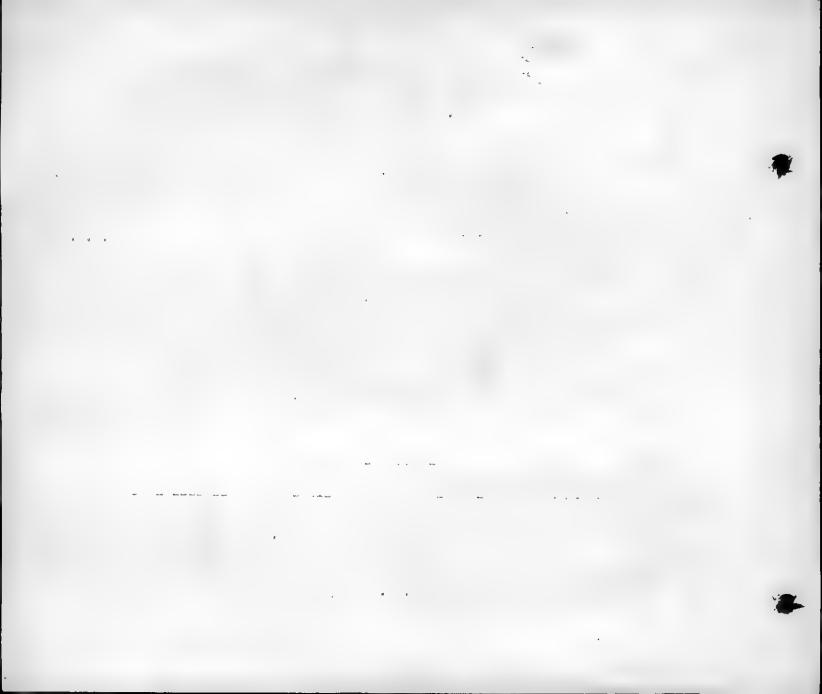
after death. Page directa Filed COUNTY funeral should NAME OF Pages FIRE S SEX Female papers. requires that the death certificate be executed ond carban physician event, with remove Unknown attending 百 þ remayal, permit. gned been si burial-transit attending phy ATTENDING PHYSICIAN: The After this detached far Health DIRECTOR: ď þe aard FUNERAL 0

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1. MARYLAND

06524 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY MARYLAND Anne Arundel timore Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) RURAL and give nearest town) 10 years C-ownsville Baltimore davs d. NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? OR INSTITUTION 316 North Parrish Street YES NO 🔼 Crownsville State Hospital Middle Manth Day Year OF DEATH Noretta Ringgold 31 60 Boston (Type or print) 19 7. MARRIED NEVER MARRIED IF JNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years last birthday) Months Days Hours August 11. 1881 Negro WIDOWED I DIVORCED | 78 100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Maryland Housekeeper 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Bradegs Thomas Boston 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (If yes, give wor or dates of service) Hospital Records Unknown 1B. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: Bronchopneumonia Hypostatic IMMEDIATE CAUSE (o) DUE TO Inanition Conditions, if ony, which gove rise to immediate DUE TO cause (a), stating the underlying couse last. Carcinoma of Breast with Metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO I 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of item 18.) 20c TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) (County) factory, street, office bldg., etc.) While a. m. Nat while p. m. 1960, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased fram. 2/3 and that death accurred at 1960 saw the deceased alive an M, from the causes and an the date stated above. 160 SIGNED ATTENDING MED. DIRECTOR STAFF PHYS PHYS. M.D. 224 PHYSICIAN 22d. ADDRESS ldegard Heard Reissman. M. D. Crownsville State Hospital, Maryland 230 BURIAL CREMATION, 236 DATE THEREOF 23CAJAME OF CEMETERY OF CREMATORY 23d. LOCATION (Cube town, or county) (Stole) REMOVAL (Specify) 24. FUNEBAL DIRECTOR'S SIGNATURE **ADDRESS** 259 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

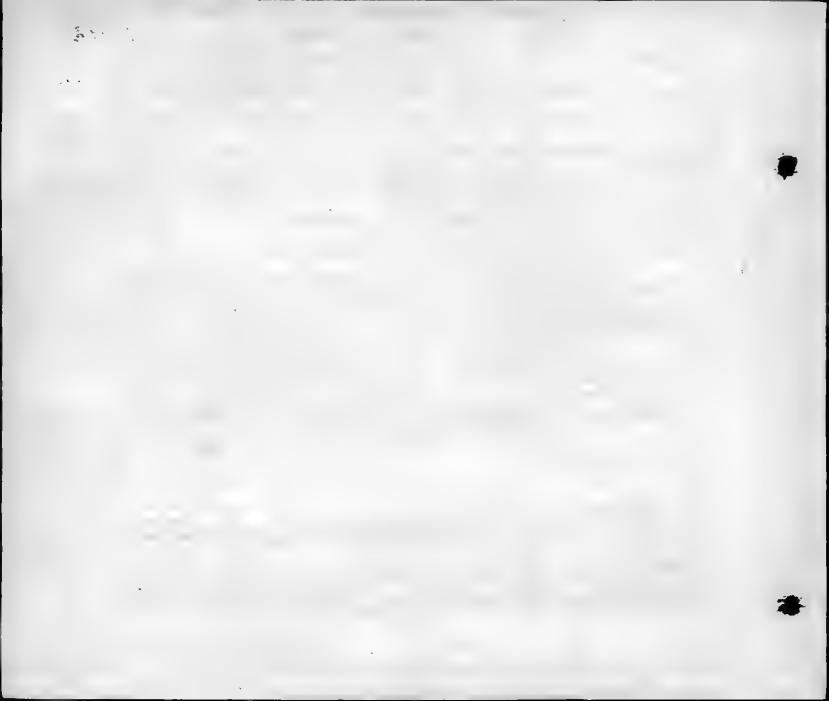
VR A15 (4) 1SM 9/59



CERTIFICATE OF DEATH

05353

| and the second | | 5319 CERTIFICATE OF DEATH | Reg. Dist. No. |
|--|----------|--|---|
| ith, lloge roll director | 1 | b. CITY OR TOWN (If putside corporate limits, write c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, | ANNE ARUNDEL |
| by the fune | | RURAL and give nearest town) ANAPOLIS d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION ANAPOLIS AN | IS RESIDENCE ON A FARM? YES NO |
| IIIn 21 hou | 3. | NAME OF DECEASED TO HIS First Middle Lost OF DECEASED (Type or print) THOMAS RUSSELL OF DEATH M SEX 6. COLOR, OR RACE 7. MARRIED 8 DATE OF BIRTH 9. AGE III | |
| npletel | 16 | MALE WHITE WIDOWED DIVORCED NOV. 21, 1880 Total bird to USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY (1) BIRTHPLACE (Stote or foreign country) | hhday) Manths Days Hours Min 12. CITIZEN OF WHAT COUNTRY? |
| ion and con carbon pap offer death. | | Oving most of working life, even if retired) OHVS IC A N FATHER'S NAME 14. MOTHER'S MAIDEN NAME | W.S. A. |
| ricote l | | JOHN HICKS RUSSELL EMILY WI WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 177. INFORMANT | H I T L Address |
| ng phy 72 ho | Ċ | To no. or unknown) If yet, give wer or deries of service) DR CARL P. RUSSE | -LL ANNAPOLIS H. |
| the death se attendi hen pleas ant within | | 18. CAUSE OF DEATH [Enter only one couse per line for (a). (b). and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE | INTERVAL BETWEEN ONSET AND DEATH |
| requires that ian. I signed by th isi permit. To and in any eve | | Conditions, if any, which gove rise to immediate couse (a), staling the under-lying cause last. DUE TO (b) ARTERIASCLEROSIS, GEA | VERTHIZE 3 321 |
| physicinos beer ial-tran | NOTA S | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITI | ON GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?, YES NO. |
| IAN: T rending ficate h the bur ar ren | CEPTIENC | | 18) |
| PHYPE tal or at this cert r use as remation | MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of work of work of work 19 to work of work 19 to w | (County) (State) |
| LOR ATTENDING DIRECTOR: After ald be detached for prior to buriof, cr. | | alive on 3-207, 1900 and that death accurred at 12 NM, from the ca ADDRESS (Street, city of ACTUAL SIGNATURE COMPANY AND MD. SHAW | Dhat I last saw the deceased suses and an the date stated abave, or town, store) DATE SIGNED |
| SALTAI INTERNATION PROPERTY OF THE PROPERTY OF | 2 | PHYSICIAN'S AMES KI MARTIN 20 BURIAL, CREMATION, 226. DATE THEREOF 225 NAME OF CEMETERY OR CREMATORY 226. LOCATION (City, | town, or county) (Stote) |
| D FUN | | BUNIAL 5-15-1960 CEDAR BLUFF CEM. ANNA | POLIS Mp |
| H H | 2 | 1. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24 | b REGISTRAR'S SIGNATURE |

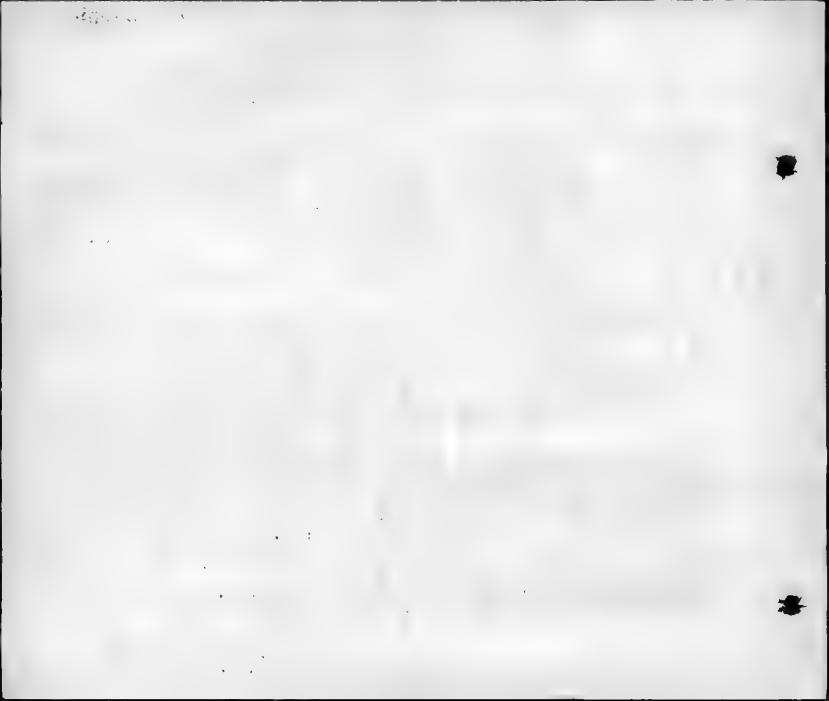


| MARYLAND | STATE DEPARTMENT OF HEALTH—BALTIMORE, | 18 |
|-----------------|---------------------------------------|----|
| 5320 | CERTIFICATE OF DEATH | |

05354

| ₽ | | | | | | | | | | | | | Keg. Dis | 1. 140. | | |
|---|--|--|-------------------|------------|-------------------|----------|--------------------------------------|---|------------|------------------------|--------------------------|---------------------|------------------------|--|--------|-------------------|
| 1 | PLACE OF DEATH o. COUNTY | Anne | Arunde | = 1 | MAI | RYLAND | 2. USU o. Si | TATE: | ce (who | | d lived. If i b. CC | nstitution DUNTY | ni Residenc Anne | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give represt fown) ATMR POLIS | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Anne Arundel General Hospital. | | | | | | | /d street ADDRESS 216 Lockwood Court | | | | | | | •. IS RESIDENCE ON A FARM? YES NOTEC | | |
| 3. | NAME OF DECEASED (Type or print) | | Addie | rst | F Midd | le | Sı | LOSI AVAGE | | 4. DATE OF DEATH | | Month May | h | Doy 23 | | Year 19 60 |
| | sex Female | | OR OR RACE ite | 7. MARR | IED NEVER MAR | | | of BIRTH | 1882 | 2 | 9. AGE (In lost birth | | Months | Doys | Hours | R 24 HRS Min. |
| 10 | during most of w | arking life, | even if retired | done 10b. | KIND OF BUSINESS | | TRY 11. | | E (Stote o | | ountry) | | 12. CITI | U.S | | COUNTRY |
| 13 | JOHN | D | GA | סס | | | 14 M | OTHER'S MA | AN | AME /DA | P. | AR | KE | P | | |
| | n, no. or unknown) | VER IN U. | S. ARMED FOR | | SOCIAL SECURITY N | 10. 17 H | NFORMA 5 | KT' ELF | | | | Addre | 155 | | | |
| | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), one (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the under. DUE TO DUE TO DUE TO | | | | | | | | | | | | | | | |
| CATION | lying couse los | THER SIGN | | | ONTRIBUTING TO D | EATH BUT | NOT REL | ATED TO TH | E TERMIN | NAL DISEAS | E CONDITIC | ON GIVE | N IN PART | I(o) 19 | PERFO | AUTOPSY PRMED? |
| CERTIFI | 20a. ACCIDENT WAS UNDERLYING A 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING EXAMINER) | | | | | | | | | | | | | | | |
| MEDICAL | 20c TIME OF INJ Hour o. n p. n | DC TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED Hour o.m. While Not while of work of work of work 19 of | | | | | | | | | ounty) | | (Slote) | | | |
| | 21. I certify that I attended the deceased from May 17, 1960, to May 22, 1960, that I lost saw the deceased alive on May 22, 1960, and that death occurred at 9:30A = M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE ACTUAL SIGNATURE ACTUAL SIGNATURE ACTUAL TO PROVIDE THE SIGNED 5/23/60 | | | | | | | | | | | | | | | |
| | HAMILE (1994) | | d S. Be | | 1 | | | | | lis, N | | | | | | |
| | REMOVAL (Speci | 7 5 | -15-1 | | ST. AN | NETERY O | - | EM | , | AN | | 24/ | 5 1 | ND | (Slote | e) |
| 23 | OHN M | -19 | R·Sow) | AUN | ADDRESS APOLIS | Mo | | | | 2 4 '60 | | | trar's sig w/t &. † | | E | |

VS A15 (4) 1SM 9/SS



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 377MEDICAL EXAMINER'S CERTIFICATE OF DEATH III ALTI LATEPT 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) L PLACE OF DEATH Health, a. COUNTY b. COUNTY director, Page is necessary, Anne Amindel Anne Arundel f.les. MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) your write RURAL and give nearest town) 75 Edgewater Edgewater d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. .5 RESIDENCE ON A FARM? Woodland Beach YES TO NO T Anne Arundel General Hospital 4. DATE Month Yaar 3. NAME OF OF DECEASED the (Type or print) DEATH 1960 CHESTER May with 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 19. AGE (In years | IF UNDER 1 YEAR, IF UNDER 24 HRS. BADATE OF BIRTH 2 with age 5 may 1 and 2 wil 72 hours a last birthday) Months MIDOWED [DIVORCED [Male White 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work KIND OF BUSINESS OR INDUSTRY Give Pages 1, 2, 2mm PM3. Page File pages 1 and rept within 72 h most of worker life, even if retired) 13. FATHER SNAME form 16. SOCIAL SECURITY NO. | 17. INFORMAL Address with for permit. (Yes, no, or unkown) | (Ifyasgivewarordatesofsarvice) 18. CAUSE OF DEATH lenter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN l-transit p ONSET AND DEATH Massive intracerebral hemorrhage IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gava risa to immediate cause DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 110) 19. WAS AUTOPSY PERFORMED? 8 YES X NO T 20b. DESCRIBE HOW INJURY OCCURED, (Entar natura of niury in Part I or Part II of item 18.) 20a, EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. MEDICAL EXAMINER: writing to Chief A Page 3 sl Month, Day, Year 20d, INJURY OCCURRED | 20e, PLACE Of INJURY (Home, farm, 1 20f. (City or town) (State) 20c. TIME OF INJURY factory, street, office bldg., atc.) Not While at work at work the P. OR: P the certificate, 21. I certify that I took charge of the remains described above, held an Autopsy K. Inspection Inquiry exacute the cermid be forwarded to NERAL DIRECTO Undetermined manner Natural causes Accident Suicide Homicide death resulted from: CHIEF MEDICAL EXAMINER ACTUAL DATE SIGNED ASSISTANT MEDICAL EXAMINER should be for FUNERAL I SIGNATURE DEPUTY MEDICAL EXAMINER Russell S. Fisher, M.D. NAME (Type) Address (Street, city, town, or county) 228 BURIAL, CREMATION 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY EMOVAL (Specify) Q40 9 unual VS. AISME anthun & Hears 5M 7/59



O FUNCTAL DIRECTOR: After this certificate has been signed by the attending physician and campletely find the by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours after death.

OR ATTERNIO PHYSICIAN: The low requires that the demain certificate be executed within 28 hours often death. Bogs

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5321

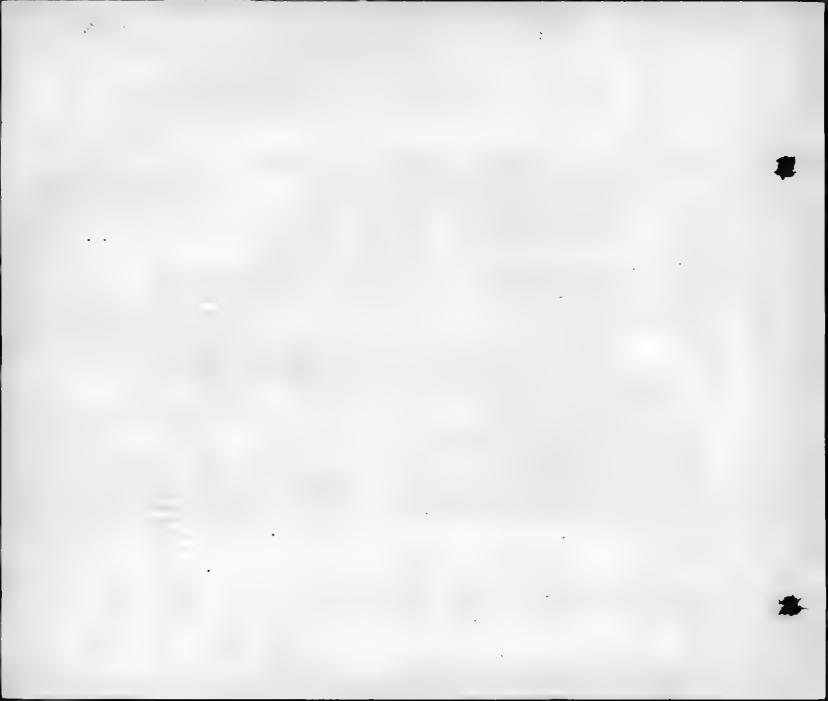
CERTIFICATE OF DEATH

05357

Reg. Dist. No.

| 1. PLACE OF DEATH o. COUNTY | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel. | | | | | | | | | | | | |
|---|--|---|----------------------------|--------|---------------|---|------------------------|---|---------------|---------|-------------------|---------|--|--|
| 0. 200 | LAND | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 11 days | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) RURAL — Shadyside | | | | | | | | |
| | | | | | | | | | | | | | | |
| Anne Arunde. | l General 1 | lospi | tal | | 1 | | | | | | E5 🗍 N | | | |
| 3. NAME OF DECEASED | Fee | st | Middle | | L | ost | 4. DATE OF DEATH | Mo | onth | Day | Yec |)r | | |
| (Type or print) | SCAR | | Lynn | | SIEGE | RT | | Ma | | 3 | 1960 | | | |
| 5. SEX | 6. COLOR OR RACE | | HED T NEVER MARRIE | | . DATE OF BIR | TH | 1 | 9. AGE (In years lost birthday) 03 yrs. | IF UNDER | YEAR IF | UNDER : | 24 HRS. | | |
| Male | White | WIDOWI | DIVORCED | | April 5 | , 1897 | | 63 r | . Months | Days F | laurs | Min | | |
| 100. USUAL OCCUPATIO | USUAL OCCUPATION [Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Slote or foreign country) 12. | | | | | | | | | | WHAT CO | DUNTRY? | | |
| Merchant drawer & STORE + Listing far by Maryland U. | | | | | | | | | | U.S. | • | | | |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER | IN U. S. ARMED FOR | CE57 16. | SOCIAL SECURITY NO. | 17, IN | FORMANT | | | ¿ Ad | dress | - | | | | |
| (Yes, no. or yoknown) | If yes, gave war or dates of s | ervice) | 1/8-14-2/30 | a I | ud E S | reger | t, 5.4 | 14451 | de | MO | /- | | | |
| 18. CAUSE OF DEA | TH [Enter only one co | use per li | ne for (a), (b), and (c).] | | | , . | | | , 1 | INTERV | AL BETW | EEN' | | |
| 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Puffure of myocardium (Cardiae temporate Sumedia | | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | | |
| Challen Warner Mushardial Ware ton | | | | | | | | | | | da | ugu | | |
| gave rise to immediate | | | | | | | | | | | | <i></i> | | |
| | cause (a), stating the under- | | | | | | | | | | | | | |
| | lying couse lost.) (c) | | | | | | | | | | | | | |
| PART 81. OTH 200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY | PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL POISEASE CONDITION GIVEN IN P | | | | | | | | | | PERFORM ES X I | IED? | | |
| OR CONTRIBUTING | 200. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | |
| 3 20c. TIME OF INJURY | f Month, Day, Ye | ar 29d II | NJURY OCCURRED | | CE OF INJURY | | | or town) | (C | ounty) | | (State) | | |
| 20c. TIME OF INJURY Hour o.m. p. m. | Hour o.m. While Not while factory, street, office bldg., etc.) p. m. 19 of work of work | | | | | | | | | | | | | |
| | 21. I certify that I attended the deceased from April 8 , 1960 , to May 2, , 1960 , that I last saw the deceased | | | | | | | | | | | | | |
| | olive on May 2, 1960, and that death occurred of 10 A.M. from the causes and on the date stated above | | | | | | | | | | | | | |
| 7 | ADDRESS (Street, city or town, stole) DATE SIGNED | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | llard | | mit | h | 1 D | Shadys | ide, | Md. | | 5, | /3/6 | 0 | | |
| PHYSICIAN'S W | NAME (Type) WILLIGITY F. SHITCH | | | | | | | | | | | | | |
| 220. BURIAL, CREMATION REMOVAL (Specify) | 5/4/60 |)F | 200 KER | | CREMATORY | | LT 2 / | ON (City, town) | or county) | red. | (State) | | | |
| 23 FUNERAL DIRECTOR'S | SSIQUATURE | 4-31 | ADDRESS | lee | 1 | | BY REGISTI | | SISTRAR'S SIG | | 4 | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND

c. LENGTH OF STAY IN 1b.

CERTIFICATE OF DEATH

Rea. Dist. No.

| | F |
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| | l |

PLACE OF DEATH

Anne Arundel

CITY OR TOWN (If outside corporate limits, write

a. COUNTY

5378

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. swieryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL and give nearest fown Burnie Baltimore 18 d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE

OR INSTITUTION ON A FARM? 2138 Harford Road 113 Allen Road YES NO T

4. DATE OF DEATH NAME OF Middle Month DECEASED 19 60 Simmons Alice Grace Mav (Type or print) 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED | 5. SEX B. DATE OF BIRTH last birthday) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Manths Days Nov. 12.1889 White DIVORCED TSC Female WIDOWED |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

Housewife 12. CITIZEN OF WHAT COUNTRY? Harford County, Md U.S.A.

14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME

William Ellis Alice R. White 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT

Address Alice V. Foster, 2138 Harford Road, ZONE 18 none

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] ONSET AND DEATH PART I DEATH WAS CAUSED BY: MYOCARDIAL INFARCTION minutes IMMEDIATE CAUSE (a) DUE TO Arteriosclerosis, generalized several Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO X

20%. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Year

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (State) (County) factory, street, affice bldg., etc.) Hour o m Nat while at work at ot work

21. 1 certify that I attended the deceased from 4-1 May 12 ____,that I last saw the deceased and that death accurred at 11: P.M. from the causes and on the date stated above. alive an April ADDRESS (Street, city or town, state)

2431 MARYLAND AVENUE 5-16-60 SIGNATURE

PHYSICIAN'S Baltimore, ELLSWORTH COOK Maryland NAME (Type) 22b DATE THEREOF 22d. LOCATION (City, town, or county) 220. BURIAL, CREMATION, 22c. NAME OF CEMETERY OR CREMATORY

Mt. Vernon Church Cemeterly, Prospect, Harford Co., Md 24g, REC'D BY REGISTRAR | 24b, REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** DATE MAY 1 7 '60 William Cook, Inc., 1217 St. Paul Street Orthun & Three

VS A15 (4) 15M 9/58

0

KAL DIRECTOR:

should



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5322 CERTIFICATE OF DEATH

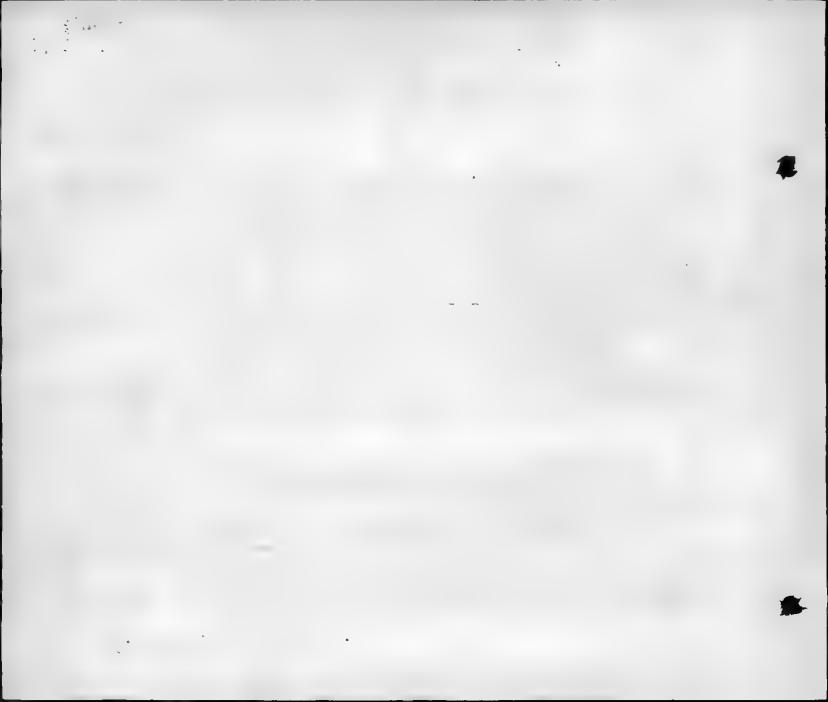
CERTIFICATE OF DEATH

05359 Reg. Dist. No.

| | | | | | | | | | 3. | | |
|---|---|---------------|----------------------------|----------|--------------------------|-------------|----------------|------------------------------------|-----------------|--------------|------------------------|
| 1, PLACE OF DEATH a. COUNTY | Anne Aru | ndel | MARYL | AND | a STATE | Maryl | | fived. If instituti b. COUNTY | | Arund | _ ' |
| b. CITY OR TOWN (If RURA), and give ne | outside corporate limi | its, write | c. LENGTH OF STAY II | N 1b | c. CITY OR T | OWN (If o | utside corpo | rote limits, write R | URAL and gi | ve nearest k | awn) |
| Annapo | lis | | 18 days | | 1 1 | Glen . | Burnie | 9 | | | |
| d. NAME OF HOSPITA | AL (If not in hospita), ç | give street | gddress) | | d. STREET A | DDRESS | | , | | e. IS | RESIDENCE N A FARM? |
| Anne Arundel | | | | | 205 4t | h Ave | ., S.Y | V. | | | □ NO T |
| 3. NAME OF | Fic | ret | Middle | | Losi | | 4. DATE | Mon | 1h | Day | Yeor |
| (Type or print) | Sarah | | | | SIMOND | S | OF DEATH | May | | 2 | 19 60 |
| 5. SEX | 6. COLOR OR RACE | 7. MARR | IED X NEVER MARRIED | 8 | DATE OF BIRTH | 1 | | 9. AGE (In years lost birthday) | IF UNDER 1 | | NDER 24 HRS |
| Female | White | WIDOW | DIVORCED | | August | 30, 1 | 890 | 69 yrs. | Months [| Days Hou | ers Min. |
| 10a. USUAL OCCUPATIO | N Give kind of work- ing life, even if retired | done 10b. | KIND OF BUSINESS OR | INDUST | RY 11. BIRTHPL | ACE (State | or foreign co | ountry) | 12. CITI2 | EN OF WH | AT COUNTRY |
| Housework | _ | | own home | | | Virgi | nia | | 1 | U.S. | |
| 13. FATHER'S NAME | | | | - | 14. MOTHER'S | | | | - | • | |
| George L | J. ^D ulaney | | | | 81 | lmedi | a Bra | dley | | | |
| S. WAS DECEASED EVER | | CES? 16. | SOCIAL SECURITY NO. | 17, IN | FORMANT | | | Add | rass | | |
| no l' | ///// | | none · | Mr. | George | s Sim | onds | San | ne As | #2 | |
| 18. CAUSE OF DEA | TH [Enter only one co | ouse per li | ne for (a), (b), and (c)] | | | | | | | | BETWEEN |
| PART I. DEAT | TH WAS CAUSED BY: | ر کے ا | britarel | 1, 1 | 1-1 | 171 | nen | relies | | S C | ND DEATH |
| , , | DUE TO | | , | - Andrew | | | | | |) | |
| Conditions, if an | ry, which) | · 14 | niperle | -10 | aine | _ C | -V'C |) | | | |
| gove rise to in | |) | VI | | | | | | | | |
| lying cause lost. | los Unger- | :) | | | | | | | | | |
| PART II. OTH | ER SIGNIFICANT CON | DITIONS C | ONTRIBUTING TO DEAT | TH BUT N | OT RELATED TO | THE TERMI | NAL DISEASE | E CONDITION GIV | EN IN PART | 1(a) 19. W/ | S AUTOPSY |
| [5] | | | _ | | | | | | | | REORMED? |
| PART II. OTH 200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY) 20c. TIME OF INJURY Hour o. m. P. m. | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 206. DES | CRIBE HOW INJURY OC | CURRED | (Enter noture of | injury in f | Part I or Part | l II of ilem 18.) | | | |
| 3 20c. TIME OF INJURY | Y Month, Day, Ye | ar 20d. II | WURY OCCURRED | 20e. PLA | CE OF INJURY () | lome, farm | , 20f. (City | or lown) | (Co | ounty) | (State) |
| Heur o.m. | 19 | While of work | Not while | rocti | ory, street, affice — | bldg., elc. | 7 | ~ | m _{ax} | | |
| | at Lattended the | deceas | ed fram Apr: | 13. | 10 60 | to M | av 2 | 19 60 | that I la | ant name th | o dorogra |
| | May 2. | 126 | | | | | | n the causes o | | | |
| dilve on | 1 | 128 | 1 / 1 | ^ | accorred ag. | | | reel, city or lawn, | | 6 0016 21 | DATE SIGNE |
| ACTUAL SIGNATURE | 1 mento | 1/19 | Alex H | · · | . 12 | 1 Cat | hedral | St. | | 5/ | 2/60 |
| , | | | 7/ | ~ | .D | | | | | | -7/ |
| PHYSICIAN'S F | rank M. Sh | ipley | | | An | na pol | is, Mo | i. | | | |
| 220. BUR AL, CREMATIO | N, 22b DATE THEREC | | 22c. NAME OF CEMET | | | | P 3 | TION (City town, | ** | | itote) |
| Burial (Specify) | | 1960 | Glen Hav | en (| Cemeter | У | le | n Burni | ≥, Mai | ryland | 3 |
| 23. FUNERAL DIRECTOR | SIGNATURE | | ADDRESS | | | | D BY REGIST | | STRAR'S SIGN | | |
| 1-Brand. | uco 2 | G | <u>len Burnie</u> | , M | d. | DATE | MAY 4 | '60 | Chillun, | S. Hrack | 4 |



| -6 | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE | , 18 0536n |
|-----|-----------|--|--|
| 4 | | 5323 CERTIFICATE OF DEATH | Reg. Dist. No. |
| | 1. | PLACE OF DEATH D. COUNTY AND 2 USUAL RESIDENCE (Where deceased lived If inst a. STATE B. COUNTY |
| M | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) A A A B A C C C C C C C C C C C C C C C | le RURAL and give nearest town) |
| | | d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION A CONTROL OF THE STREET ADDRESS OR INSTITUTION | e. IS RESIDENCE ON A FARM? YES NO |
| 100 | L | (Type of print) FLOW DEATH 5- | Month Day Yeor |
| | | | yrs. Months Days Hours Min. |
| | | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired) | CL . S |
| 1 | L | Curistortion for the standards. It mother's mailen name. | the themen |
| (1 | | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 17. INFORMANT 216-05-7072 | Address / |
| | | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I, DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) DUE TO | INTERVAL BETWEEN ONSET AND DEATH |
| | | Conditions, if any, which gave rise to immediate couse (o), stoling the <u>under-lying couse lost.</u> (b) DUE TO (c) | n, |
| | ICATION | PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION | PERFORMED? YES NO |
| | IL CERTIF | 20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port 11 of item 18 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | MEDICAL | 20c. TIME OF INJURY Manth, Day, Year Haur a. m. p. m. 19 20d. INJURY OCCURRED While Nat while at work at wo | (County) [State] |
| 1 | | 1 f 3 | that I last saw the deceases and an the date stated above, state) DATE SIGN |
| | | ACTUAL SIGNATURE SIGNATURE STORY ACTUAL SIGNATURE SIGNAT | 16112 5-28 |
| | 22 | BURIAL CREMATION, 228. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, 10) | ** |
| * | 23. | Burial 15/30/60 Drug d Pidgo Com FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS 240. REC'D BY REGISTRAR 246. R DATE MAY 3 1 '60 DATE MAY 3 1 '60 | TEGISTRAT'S SIGNATURE CINEMA S. THERE |
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a. COUNTY

3. NAME OF

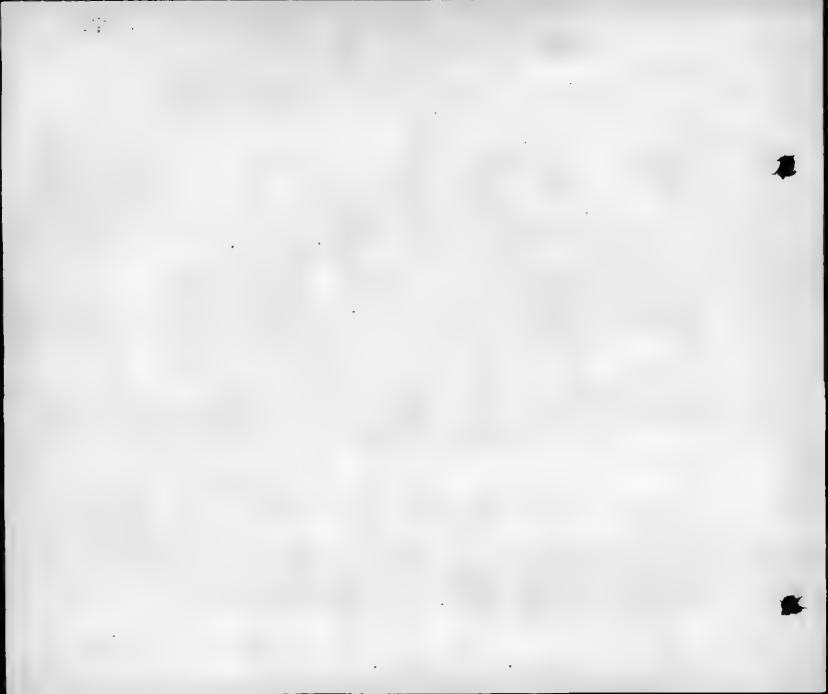
5. SEX

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05361 XAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If Institutions Residence before admission) PLACE OF DEATH o. STATE Same MARYLAND Anne Arunde b. CITY OR TOWN (If publide corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and give negrest lown Point Pleasant Glen Burniel 6 vears Same d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? Mear a shed Dox 209 Route 2 Same YES NO I Middle 4. DATE OF Month Year (Type or print) DEATH May 15th. Nicholas Andrew Steinbach 19 60 6. COLOR OR RACE 7. MARRIED [NEVER MARRIED] 8. DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS. lost birthdayt Months Days Hours Min. WIDOWED | DIVORCED | & yes. 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) USA Retired seaman and night watchman Baltimore .Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Elizabeth 17. INFORMANT 16. SOCIAL SECURITY NO. Address 101-10-1653 Mrs. Nedia Steinbach (wife INTERVAL BETWEEN Sudden Coronary Occlusion IMMEDIATE CAUSE (a) DUE TO DUE TO PERFORMED? NO X 20b. DESCRISE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.)

John Steinbach 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c), PART I, DEATH WAS CAUSED BY: Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160/19 WAS AUTOPSY CATION CERTIF 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | 20c. TIME OF INJURY Month, Day, Year 20d. INTHRY OCCURRED 20e. PLACE OF INJURY (Home, form, 120f. (City or town) (County) (Stote) factory, street, office bldg., etc.) While Hour a.m. Not while al work al work p. m. 21. I certify that I taak charge of the remains described above, held an Autapsy . Inspection 2 Inquiry 4. and find that death resulted fram: Natural causes X, Accident , Suicide , Homicide , Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATUS ASSISTANT MEDICAL EXAMINER **EXAMINER'S** Gustave H. Faubert, M.D. DEPUTY MEDICAL EXAMINER [X] NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) Glen Burnie. Md. Buria Glen Haven 246. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a, REC'D BY REGISTRAR DATE MAY 1 8 '60 JOHN F. DENNY, INC. 715 Light St. -30

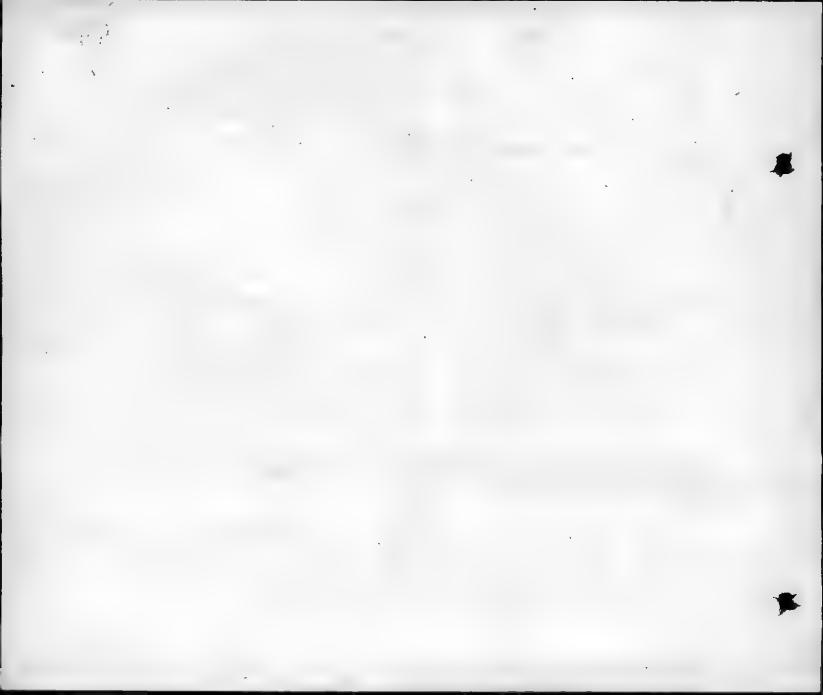
VS. A15ME(5) 5M 9/55



05364 5324 CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL IJESIDENCE (Where decilosed lived, If institution: Reingence before, admission) a. COUNTY a. STATI filed COUNTY eral CITY OR TOWN (If autside corporate limits, c LENGTH OF STAY IN 16 TYOR TOWN (If autside carparate limits, write RUBAL and give nearest town) KURAL and give nearestytavym Fun shaufd give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 26 YES NO X NAME OF Middle DATE Day Year DECEASED (Type or print) DEATH 196 5. SEX 6. COLOR OR RACE 7. MARRIED 🖪 NEVER MARRIED 🔲 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last burthday) Manths Doys Hours WIDOWED [DIVORCED yrs. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even Treptred) 12 CITIZEN OF WHAT COUNTRY? 8 puo pgu 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physicion remave 15. WAS DECEASED EVER IN ARMED/FORCES? 16. SOCIAL SECURITY NO -INFORMANT Address aftending edse CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO ģ permit. ony Canditions if any, which (b) te has been signed burial-transit permi gave rise to immediate **DUE TO** Ξ. cause (a), stating the underand lying cause lost. CERTIFICATION PART II. OTHER'S GNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY maval, PERFORMED? YES NO TO 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of n'ury in Port I or Port II of item 18) certificate (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, 20f, (City or town) (County) (State) factory, street, affice bldg., etc.) Haur a.m. While Nat while at work at work 21. I certify that I attended the deceased from . 19.4 S., ta 1984, that I last saw the deceased alive on and that death accurred at IEM, from the causes and on the date stated above. by the TO FUNERAL DIRECTOR: DATE SIGNED ADDRESS (Street, city or town, state) ACTUAL ained SIGNATURE page 3 shauld PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF JAME OF CEMETERY OR CREMATORY 22d_LOCATION (City town, or bountly) REMOVAL (Specify) FUNERAL-DIRECTOR'S SIGNATURE **ADDRESS** 24a, REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE Cirthur S. Firess VS A15 (4) DATEMAY 26 15M 9/58

death. Page

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1, MARYLAND 05362 CERTIFICATE OF DEATH directar 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 1. PLACE OF DEATH Filed o. STATE b. COUNTY MARYLAND eral OF TOWN (If outside corporate rimits c. LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give negrest town? þe e IS RESTDENCE haspital, give street address ON A FARM? 20 YES TO NO TE DATE OF DEATH NAME OF Year DECEASED File death. (Type or print) sall o CO9C 6. COLOR OR 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX MARRIED NEVER MARRIED 8. DATE OF BIRTH Months Days Hours DIVORCED [papers. 10a. LISUAL OCCUPATION (Give kind of work done during most of working life; even if retigid) 12 CITIZEN OF WHAT COUNTRY? and 13. FATHER'S NAME physicion remove IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT Address ottending pleose 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE DUE TO Canditians, if any, which gave rise to immediate **DUE TO** couse (a), stoting the underlying cause lost. **burial-transit** ONT CONDITIONS CONTRIBUTING TO DEATH BUT NOTRELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS YES 🗀 NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Jun II of item 18.) 20c. TIME OF INJURY Month, 20d INJURY CCURRED 20e PLACE OF INJURY (Mome, farm, 20f. (City or town) Year (County) (Stote) Hour Co m factory, street, office bldg., etc.) While Not while 19 at work at work p. m detached for 6Chat (1) (we) last 21 I certify that (I) (this haspital) altended the deceased from and that death accurred A, from the causes and an the date stated abave. the deceased alive an DIRECTOR: SIGNAL 22by DATE ATTENDIN pe PHYS. DIRECTOR [PHYS. Sined 22d. ADDRESS FUNEKAL 230 BURIAL, CREMAT ON. DATE THEREOF OBJEEMETERY OR CREMATORY 23d LOCATION (City ,town, or county) 23b. 23c NAME (Stote) 2 24 FUNERAL DIRECTOR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE ADDRESS D BY REGISTRAR VR A15 (4) DATE Cirthur & House 1SM 9/59

death.



| (F) | 180- | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE | , 18 |
|---|--|--|--|
| ∀ 2€ | 1/4 | 5334 CERTIFICATE OF DEATH | U5363 Reg. Dist. No. |
| rath: Page erol directo be filed wit | \widehat{M} | 1. PLACE OF DEATH O. COUNTY D. COUNTY B. CITY OR TOWN (If outside corporate limits, write RURAL and give peocest lows). E. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give peocest lows). | NTY , , , |
| s after dec y the funer 2 should b | <u> </u> | d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS | Mystry o IS RESIDENCE ON A FARM? |
| in 24 hour | X | (Type or print) DEL MOLL, Stychicoup DEATH 5- | Manth Day Year |
| nted with mpletely sers. Pa | • | 5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9. AGE (In yellost birthdo 49) 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) | yrs. |
| ရှိ စီရှိ | THE OPENIES OF THE OP | Maching most of working life, even if retired) Md. Drydock 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| - Till | Lookity Control | | Address Ave Andrey Ave |
| the death he ottendi hen pleos | ent within | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CAUSE (c) May be considered. | INTERVAL BETWEEN ONSET AND DEATH |
| gned by I permit. T | אַ מטאל פּר פטע פטער | Conditions, if ony, which gove rise to immediate couse (a), stoting the under. DUE TO DUE TO | |
| he faw rec physicion. Ias been si iol-transit | oval, ond | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION OF 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING OF CONTRIBUTION O | GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| CIAN: T | n or rea | | |
| G PHYSI or a little or a little cer in this cer in the | | 20c. TIME OF INJURY Month. Day. Year 20d. INJURY OCCURRED Hour a. m. 19 While of work of work foctory, street, office bldg., etc.) | (County) (State) |
| ATTENDING by the hosp CTOR: After detached f | | olive on 12, and that death accurred at 144 M, from the cause. ADDRESS (Street, city on you | s and an the date stated abave. DATE SIGNED |
| gined should be | | PHYSICIAN'S ROPERT DELAND DEC | 3-3/-6/ |
| TO HOS moy b TO FUN | b | 220. BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, low REMOVAL (Specify) 3 June 1960 6/en Haven Cems 6/en 3477. 23. FUNERAL DIRECTOR'S SIGNATUR 24 ADDRESS | 18, Md. |
| VS A15 (4) 15M 10/57 | * | P. L. W denstitue Glow Brewers 1940 REL D BT REGISTRAR 1240. RE | COUSTRANTS SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be hained by the hospital or attending physician. TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and completely filling his py the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remean carbon pagers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 harrafeed each.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5381

CERTIFICATE OF DEATH

05365 Reg. Dist. No.

| | LACT OF BEATH | | | A | 46.5 -355567.4 | | |
|---------------|---|------------------------|------------------------------|--------------------------|---------------------------|------------------|--------------|
| | county AA. Co | MARYLAND | 2. USUAL RESIDENCE (W | | COUNTY A | de before odmi | ission) |
| 1 13 / | /RURAL and give negrest town) | ENGTH OF STAY IN 16 | Y3, | outside corporate limi | - A | ive nearest to | rn) |
| $X \cap$ | TILLISMERE SHOTTES | | HILLSMER. | ED HORES | RURAL/+1 | UNA PO | 5215 |
| 1. | NAME OF HOSPITAL III not in hospital, give street address on arrival). | rss) | d. STREET ADDRESS | | | | A FARM? |
| An | ne arundel General Hospita | L | DAY VIEW | URIVE | | YES [| NO KO |
| } 0 | Type or print) DONALD First Type or print) | Middle 5 | weamy | 4. DATE OF DEATH | Month May | 0 ₀ y | Yeor 1960 |
| S. S | EX 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | 9, AGE | (In years IF UNDER Months | | |
| | MALE WHITE WIDOWED | | 6-9-14 | 00 3 | 4 yes | Days Hour | Min. |
| 10a. | USUAL OCCUPATION (Give kind of work done 10b. KIND during most of working life, even if retired) ALES KEPRESENTATIVE | OF BUSINESS OR INDUS | STRY 11. BIRTHPLACE (STOP | o or foreign country) | 12. CITI | SA | T COUNTRY? |
| | FATHER'S NAME | , | 14. MOTHER'S MAIDEN | NAME | | | |
| | BARUCH W. DWE | ANY | MARY | KULLM | AN | | |
| | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCI | AL SECURITY NO. 17. II | NFORMANT | - 20 | Address | 44 0 | |
| | | 10 | ARGUEKIT | E D Su | UEANY | #2 | |
| | 18. CAUSE OF DEATH [Enter only one couse per line for | | | | 0 1 | INTERVAL E | |
| | PART I. DEATH WAS CAUSED BY: | etral N | arcula | dow | dut | Do | A. |
| | DUE TO | 1-1 | - | | | 1 | 7 |
| | Conditions, if ony, which gove rise to immediate (b) | mun | w on | | | 10 | yen |
| | couse (a), stoting the <u>under</u> . DUE TO | | | | | | |
| z | PART II. OTHER SIGNIFICANT CONDITIONS CONT | PIRUTING TO DEATH RUT | NOT RELATED TO THE TERM | AINAL DISEASE COND | ITION GIVEN IN PART | T I/o1 19 WAS | SAUTOPSY |
| ATIO | | | | mine order to College | | PERF | ORMED? |
| CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE OR CONTRIBUTING CAUSE OF DEATH | HOW INJURY OCCURRE | D (Enter nature of injury in | Port I or Port II of ite | pm 1B.) | 1.20 | J |
| CER | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | |
| MEDICAL | | | ACE OF INJURY (Home, for | m. 20f. (City or town | i) (C | ounty) | (Stote) |
| MED | | of work | ctory_sumet, office bldg., e | (c.) | | | |
| | 21. I certify that I attended the deceased f | ram 4-20 | Z. 1960 to | 5-22 | 18 6 that 11 | ast saw the | e deceased |
| 11 | | | occurred allo:24 | P •M. fram the o | causes and on th | ne date sta | ted abaye. |
| | Fre (mall) | 10. | | ADDRESS (Street, city | | | DATE SIGNED |
| | ACTUAL SIGNATURE | Sey | M.D. 121 Va | thedral St | | 5/ | 23/60 |
| | PHYSICIAN'S Frank M. Shipley | | Annap | olis, Md. | | | |
| 220. | | NAME OF CEMETERY O | R CREMATORY_ | 22d JOCATION (CI | ty, town, or county) | (S) | ote) |
| 1.1 | PLIPIAL MAY 24-1960 H | ILLCREST | MEM.CEM | ANNA | POLIS | M | D. |
| 23. | FUNERAL DIRECTOR'S SIGNATURE | ADORESS | 24a. REG | | 24b. REGISTRAR'S SIG | SNATURE | |
| V | OHN M. YAYLOR, SOWS AL | VVAPOGIS | ND DAMA | Y 2 4 '60 | arthur S. A | Traine | |

VS A1S (4) 1SM 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05366

| / | The la Dilettock (| |
|---------|---|--|
| | 1. PLACE OF DEATH O. COUNTY AMBE AVUNCE MARYLAND | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission), o. STATE Mary (and b. COUNTY |
| | CROWNSVILLE 6 Mos.5 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V / 4 |
| April 1 | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNS VILLE STATE HOSPITAL | 102 West Savatoga St. On a FARM? YES NO NO NO NO NO NO NO NO NO NO NO NO NO |
| | 3 NAME OF DECEASED [Type or print] TA First Middle TA | OMPSON 4. DATE Month Day Year 1960 |
| | S SEX Male 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | ADN. 21884 9 AGE (In years Internal of the property of the pr |
| | 100. USUAL OCCUPATION (Give kindlof work done 10b. KIND OF BUSINESS OR INDU- during most of working life, every firefred) | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| / | 13. FATHER'S NAME PSON JOHN H. Thompson | 14 MOTHER'S MAIDEN NAME LOWER LAINES |
| | S WAS DECEASED EVER IN U S ARMED FORCES? 16. SOCIAL SECURITY NO 17 IF yes no. oc unknown) (If yes give yer or doles of service) with the will be service) with the will be service. | Medical Recotal Address |
| | 1 dote the to thinked be t | rol Hemorrhage ic cardio vascular ditease theriosclerosis |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 200 ACCIDENT WAS UNDERLYING COR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED 20c. DESCRIBE HOW INJURY OCCURRED | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO [|
| | | D. (Enter nature of injury in Part I or Part II of item 18.) |
| | | ACE OF INJURY (Home, farm, 20f (City or town) (County) (State) ctary, street, office bldg., etc.) |
| | 220. SIGNATURE | death accurred at the form the causes and an the date stated above 22b.DATE SIGNED PHYS. DIRECTOR PHYS. |
| | 230 BLY AL CREMATION 23b DAY THEREON 23c NAME OF CEMBERRY DO | OR CREMATORY 23/200/TION (City, town, Jacoupt) (Sold) |
| | SUNERAY DIRECTOR'S SICHONOMER ADOPESS | V COM MUNC 1 TON Md. |
| | Latter R. W. William 322 Schoolangs | DATEMAY 25 '60 Orthur S. Krong |

TO HOSPING OR EXTENDING PHYLICIAN: The low equires that the death certificate be excelled within 24 agusts after death. Page 4 may consider by the hospital or attending physician.

TO FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remays carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremotian, ar removal, and in any event, within 72 haurs after death.

VR A1S (4) 1SM 9/S9

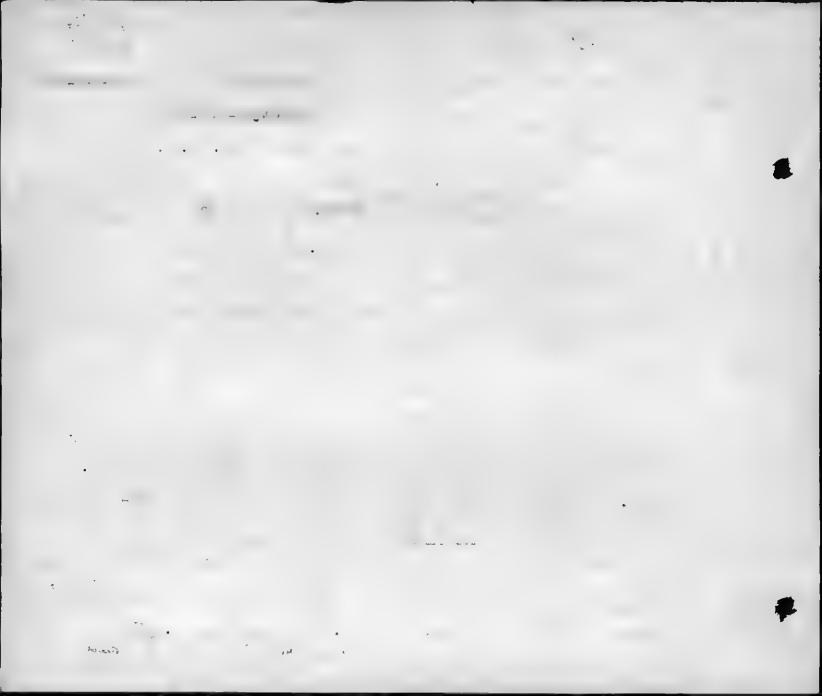
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 5325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decassed lived, if institution; Ras dance before admiss on director. Page or your files. a. COUNTY Health, a. STATE b. COUNTY is necessary, Anne Arundel County MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (f outside corporate limits, write RURAL and give nearest fown ┪ write RURAL and give rearest town) Armapulis
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) TO. Boar d. STREET ADDRESS a. IS RESIDENCE funeral ON A FARM? State Anne Arundel General Hospital 1338 Eastrate Ave., YES NO 3. NAME OF M ddla 4. DATE Yaar DECEASED 3 to the OF Campbell ihe e (Typa or print) DEATH 60 May 19 THURSTON With S. SEX 6. COLOR OR RACE 9. AGE (In years) F UNDER 1 YEAR 8. DATE OF BIRTH IF UNDER 24 HRS. may 2 2 with 2, and 5 may nd 2 with hours rast birthday) Hours Days Male DIVORCED X sugust 9 10a USJAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country, 12. CITIZEN OF WHAT COUNTRY? Page 79 dona during most of working life, even if retired) in pencil in Item 18, Give Pages Carpenter Construction Segred 14. MOTHER'S MAIDEN NAME P.M.3. FATHER'S NAME George Benjamin Thurston Celia Haga event form This certificate should be executed within 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 116. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yas, no, or unkown) | (If yes give war or detes of service) Office along with fabrical burial-transit permit moval, and in any e Gakey Funeral Home, Roanoke, Va 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Drowning IMMEDIATE CAUSE (a) DUE TO removal, Conditions, if any, which (b) geve rise to immadiata causa "pending" Examiner's 40 DUE TO (a), stating the underlying NS NS cause last. cremation, PART II. OTHER SIGNIF, CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19, WAS AUTOPSY CERTIFICATION PERFORMED? execute the certificate, writing the word Id be forwarded to the Chief Medical E. 28 Medical should by YES 🙀 NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of Item 18.) PRIMARY TO OF CONTRIBUTING TO uld be forwarded to the Chief Me NERAL DIRECTOR: Page 3 sho designated agent, prior to burial, MEDICAL EXAMINER: CAUSE OF DEATH. Deceased stumbled and fell from houseboat into water. 20d. INJURY OCCURRED 20e, PLACE OF NJURY (Home, farm, 20f. (City or lown) 20c. TIME OF INJURY Month, Day, Year (County) (State) factory, street, offica b.dg., etc.) Not While While South River Park- Anne Arundel al work at work Houseboat 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Accident T Undetermined manner Natural causes Suicide 1 Homicide CHIEF MEDICAL EXAMINER [ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED should be for FUNERAL 1 SIGNATURE DEPUTY MEDICAL EXAMINER May 26, 1960 EXAMINER'S NAME (Typa) Address (Street, city, Town, or county) 22a, BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, lown, or country) REMOVAL (Spacify) ₹40 2 purial FUNERAL DIRECTOR Cedar Lawn Roanoka Co. 24s. REC'D 8Y REGISTRAR | 24b. REGISTRAR'S SIGNATURE Switzer L. Haus VS. ATSME 5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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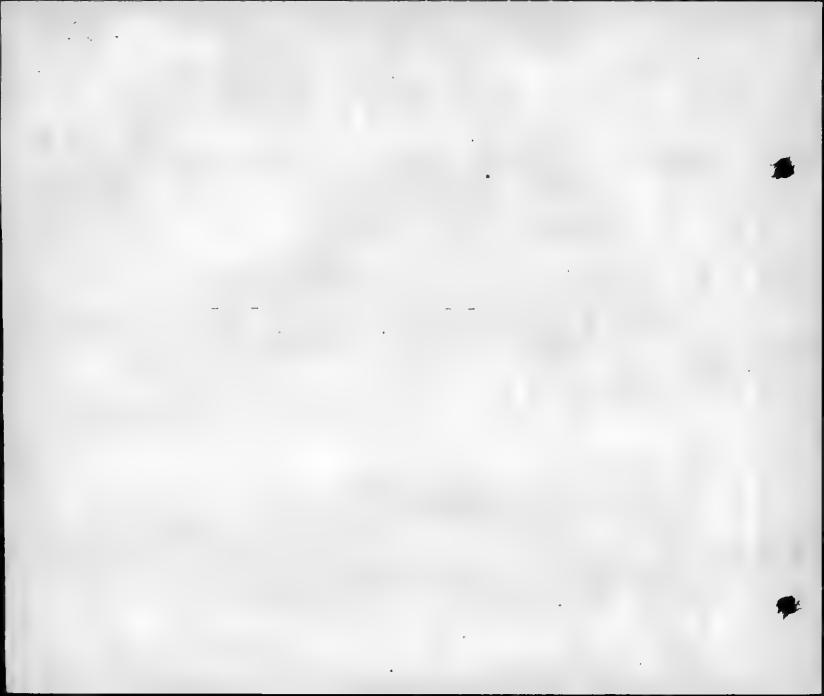
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05369

Reg. Dist. No.

| b. CITY OR TOWN IF consider composes knah, write RURAL and give necreat form) Annap 1is A NAME OF NOSTITAL OR INSTITUTION (If not in begains), give street address) Anne Arundal General Hospi al Middle Anne Arundal General Hospi al NAME OF THE MIDDLE ANNA WARRIED NETTERNAL OR PARTY FOR THE MIDDLE ANNA WARRIED NAME OF THE MIDDLE ANNA WARRIED NOTE OF PINN THERESIA ANNA WARRIED NEVER MARRIED NEW THERE STANDE TO SHOOM AND THE STANDE NEW THERE STANDE NEW THERE STANDE NEW THERE STANDE NAME FAIL ID NOT 2 NAME OF THE STANDE NAME OF | i. PLACE OF DEATH O. COUNTY anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE Maryland b. ENUMEY Arundel | | | | | | | | | |
|--|---|------------------------|--|----------------|--|---------|--------------------|--------------|----------------|---------------------------------|------------|----------|------------|-----------|
| ANAME OF HOSTITAL OF INSTITUTION (If not in hospital, give street address) A. NAME OF ANAME OF THE PROSESTA ANNA MIGGINE 3. NAME OF THE PROSESTA ANNA MIGGINE 3. NAME OF THE PROSESTA ANNA MIGGINE 3. NAME OF THE PROSESTA ANNA MIGGINE 5. SEX OLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 16 19 CO 5. SEX 6. COLOGO OF REACE 7. MARRIED 18. DATE OF BIRTH 18. DECEMBER 18. DATE OF BIRTH 18. DATE OF | <u> </u> | | | | | | | | | | | | | |
| Anne Arundel General Hospital NAME OF First | Ι. | and give nearest town] | | NUKAL | e. televin or sixe | 126 10 | | | | | NONNE GIN | o give n | edies: 101 | wash |
| Anne Arundel General Hospital Anne Arundel General Hospital Anne Hospital General Hospital Anne H | - | | | If not in hosp | ital, give street address | 1) | d. STREET A | DDRESS | | | | | e, IS RI | ESIDENCE |
| THERUSIA ANN WAGNER S. SEX S. SEX S. SEX S. G. COLOR REACE T. MARRIED NEVER MARRIED S. DATE OF BIRTH DIVONED JULY 15, 1884 TO HUNDER LYEAR IT UNDER LYEAR IT U | | Anne Arur | ndel Genera | 1 Hos | oi-al | | | | | | | | YES. | NO 🗌 |
| THERUSIA ANN WAGNER S. SEX S. SEX S. SEX S. G. COLOR REACE T. MARRIED NEVER MARRIED S. DATE OF BIRTH DIVONED JULY 15, 1884 TO HUNDER LYEAR IT UNDER LYEAR IT U | 3. | NAME OF | F)r; | șt . | Middle | | Last | | 4. DATE | | | | Y | ear |
| Township White Widowed Divorce July 15, 1884 Township Day Mount Min. Months Day Mount Min. Mounth Day Mount Min. Mounth Day Mounth Min. Day Mounth Day | | | THERE | SIA A | NIVA WAGNER | | | | | May | 16 | | 1 | 9 60 |
| Too. USUAL COLUMNION (Sive island of evot done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPIACE (Siote or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA | 5. 5 | iEX . | 6. COLOR OR RACE | 7- MARRIEI | NEVER MARRIED | 8. | DATE OF BIRTH | | | 9. AGE (In years ion) building) | | | | |
| during most of working life, even if refired) OWN home Hungary USA | | Female | White | WIDOWED | DIVORCED [| | July 1 | 5, 18 | 84 | | | Days | Hours | Min. |
| 13. FATHER'S NAME Phillip Mori 2 15. WAS DECEASED FYER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT NO. 18-36-4507 ir Charles Wagner—Son—same as # 2 18. CAUSE OF DEATH [Enfar only one couse per line for [o], (b), and (c). 17. INFORMANT NO. 18-36-4507 ir Charles Wagner—Son—same as # 2 18. CAUSE OF DEATH [Enfar only one couse per line for [o], (b), and (c). 17. INFORMANT NAME OF THE PART I. DEATH WAS CAUSED BY: NAMEOLATE CAUSE OBLIGHT (C). 18 OF THE PART I. DEATH WAS CAUSED BY: NAMEOLATE CAUSE OBLIGHT (C). 19 WAS AUTOPSY PERFORMED 20. DUE TO Conditions, if only, which gove rise to immediate couse (c), stoling the underlying Course foat. 21. OTHER SIGNIFICANT CONDITIONS CONTREUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19 WAS AUTOPSY PERFORMED 22. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 23. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 24. THE OF INJURY Month, Day, Year Work of While of Work of Part II of item 18.) 25. CAUSE OF DEATH. 26. Industry Hour o. m. 19 of work of part II of item 18.) 27. I certify I hort Took charge of the remains described above, held an Autopsy [], Inspection [], Inquiry [], and find that death resulted from: Matural causes []. 27. ACTUAL 28. SUPRIA CERNATION, 126. DATE THEREOF 19 SUPRIA CERNATION, 126. DATE THEREOF 29 SUPRIA CERN | 100 | . USUAL OCCUPATIO | N (Give kind of work of life, even if retired) | done 10b. Ki | | INDUSTI | | | or foreign (| country) | | | F WHAT | COUNTRY? |
| Phillip Mori 2 15. WAS DECEASED EVER IN U. S. ARNED FORCES? Id. SOCIAL SECURITY NO. 17. INFORMANT 18-36-4507 Vir Charles Wagner - Son - Same as # 2 18-36-45 | | | wife | | own home | | | | | | | JSA. | | |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 17. INFORMANT 18. CAUSE OF DEATH 18. CAU | 13. | FATHER'S NAME | | | | | | | | | | | | |
| Ten. no. prunnersh Playsic give root or downs of survival Playsic give rise to immediate course (a), stabiling the underlying course lost. Part II. Other significant conditions. If only, which gove rise to immediate course (a), stabiling the underlying course lost. Part III. Other significant conditions contributions | | | | | | | Marga | aret | (Unkn | own) | | | | |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o). (b). and (c). Cr., 1 yocarditis, PART 1. DEATH WAS CAUSE OF MEMBRINE CAUSE (o) Conditions, If only, which gove rise to immediate couse (a), stating the underlying course lost. DUE TO Conditions, If only, which gove rise to immediate couse (a), stating the underlying course lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? YES NO EXTERNAL CAUSE WAS PERFORMED? 20. EXTERNAL CAUSE WAS PERFORMED? YES NO EXTERNAL CAUSE WAS PERFORMED. YES NO EXCENDED. YES NO | | | | service) | | | | | | | | | | |
| PART I. DEATH WAS CAUSE 087 INMERIOR FOR THE PART II. ONLY Which DUE TO Conditions, If only, which gove rise to immediate cause (cl), stoling the underlying Couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT C | | no | no | 21 | 8-36-4507 | Mir | Charles | Wagn | er- S | on- same | as # | 2 | | |
| PART I. DEATH WAS CAUSE 087 INMERIOR FOR THE PART II. ONLY Which DUE TO Conditions, If only, which gove rise to immediate cause (cl), stoling the underlying Couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT CONTR. BUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PART II. OTHER SIGNIFICANT C | | 18. CAUSE OF DEAT | H [Enlar only one cou | se per line f | or (o), (b), and (c).] | בידל : | Vocard | itis. | | | | INTE | TVAL BETWE | EN ATH |
| Conditions, If only, which gove rise to immediate cause (a), stoling the underlying cause fort. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES NO (2) 200. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) Natural causes 201. I cause of INJURY Month, Day, Year White Not white of work of endows, street, office bidg., etc.) 202. I certify that Took charge of the remains described above, held an Autopsy Inspection Industry (Inquiry Inquiry | | | | | | | | | | | | | | |
| Conditions, If only, which gove rise to immediate cause (a), stoling the underlying cause fort. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES NO (2) 200. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) Natural causes 201. I cause of INJURY Month, Day, Year White Not white of work of endows, street, office bidg., etc.) 202. I certify that Took charge of the remains described above, held an Autopsy Inspection Industry (Inquiry Inquiry | | : 43 | DUE TO | | Auricullar | Fib | rillatio | on . | femo: | ral thro | nbosis | | | |
| Col. Stating the underlying Oue to right leg. | | | | | | | | , | | | | | | |
| PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? PERFORMED. Store May 19, 1960 Store May 19, 196 | | | | | right leg. | | | | | | | | | |
| PERFORMED? YES NO YES | | | (c) | | | | | | | | | <u> </u> | | |
| 20c TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, p. m. 19 work of wor | Š | PART II, OTHI | ER SIGNIFICANT CON | DITIONS CO. | NTR-BUTING TO DEATH | BUTN | OT RELATED TO | THE TERMI | NAL DISEAS | E CONDITION G | VEN IN PAR | T 1(o) 1 | 9 WAS | |
| 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, how month, p. m. 19 work of | Y | | | | | | | | | | | | | |
| 20c TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, p. m. 19 work of wor | J. | 20g. EXTERNAL CAU | SE WAS 20 | b. DESCRIBE | | | | ury in Port | l i or Part II | of item 18.} | | | | |
| 21. I certify that Took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Matural causes , Actident , Suicide , Homicide , Undetermined cause . ACTUAL RESIDENT | ä | CAUSE OF DEATH. | II KIBU IING | | Natural | cau | ses | | | | | | | |
| 21. I certify that Took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Matural causes , Actident , Suicide , Homicide , Undetermined cause . ACTUAL RESIDENT | Š | | Y Month, Day, Yes | 97 20d. II | JURY OCCURRED 20 | e PLAC | E OF INJURY (H | lome, form | 20f. (Cit) | y or town) | (Co | unty) | | (State) |
| 21. I certify that Took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Matural causes , Actident , Suicide , Homicide , Undetermined cause . ACTUAL RESIDENT | AED. | | 19 | | k per work | racto | ry, street, office | blog., erc.; | ' | | | | | |
| death resulted from: Matural causes A Accident , Suicide , Homicide , Undetermined cause . ACTUAL SIGNATURE | | | or Took charge | | | abov | e. held an | Autopsy | v 🗖. I | nspection X | Inqui | rv Di | and | find that |
| ACTUAL SIGNATURE | | | 1 70 4 | - | L-7 / | | | 1 1 | | | | . — | | |
| SIGNATURE SIGNATURE ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) May 19, 1960 St. Mary's Geme'ery Annab lis laryland 22 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | | | /// | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 9 | , | 51111-21-0-0 | L, , | | | 3. | | |
| EXAMINER'S NAME (Type) Elmer G. Linhardt DEPUTY MEDICAL EXAMINER DEPUTY DEPU | | ACTUAL | 1 | | har AL | - | CHIEF M | EDICAL EX | AMINER T | 1 | | | DATE S | IGNED |
| EXAMINER'S NAME (Type) Elmer G. Linhardt DEPUTY MEDICAL EXAMINER 220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Burial May 19, 1960 St. Mary's Comedency Annapolis, Naryland 22 FUNERAL DIRECTOR'S SIGNATURE ADDRESS DEPUTY MEDICAL EXAMINER 22d. LOCATION (City, town, or county) (Stote) Annapolis, Naryland 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | | SIGNATURE | Jan. | 7 | - July | | _M.D. | | | _ | | | | |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Slote) Burial May 19, 1960 St. Mary's Geme'ery Annab lis Laryland 22 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | | EXAMINER'S | lmon G. Ida | hondt | | | | | | | | | | |
| REMOVAL (Specify) Surial May 19, 1960 St. Mary's Gere'ery Annap lis Varyland ADDRESS 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE | 220 | | | | 22c. NAME OF CEMETE | RY OF | | | | | or county) | | (Slate | eì |
| 22 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246. REC'D BY REGISTRAR'S SIGNATURE | | REMOYAL (Specify) | | | | | | | | | | 7 | for Del | -, |
| they of all all and a | 23 | | | | | O.B. | | 24g. REC'1 | | | | | RE | |
| How ing I mared Jones Annapolis, "I. DATEMAY 19'60 Oribus & Known | 0 | Short XI | Youth | -N | | 4 | | | | | | | | |

VS. A15ME(5) 5M 9/55

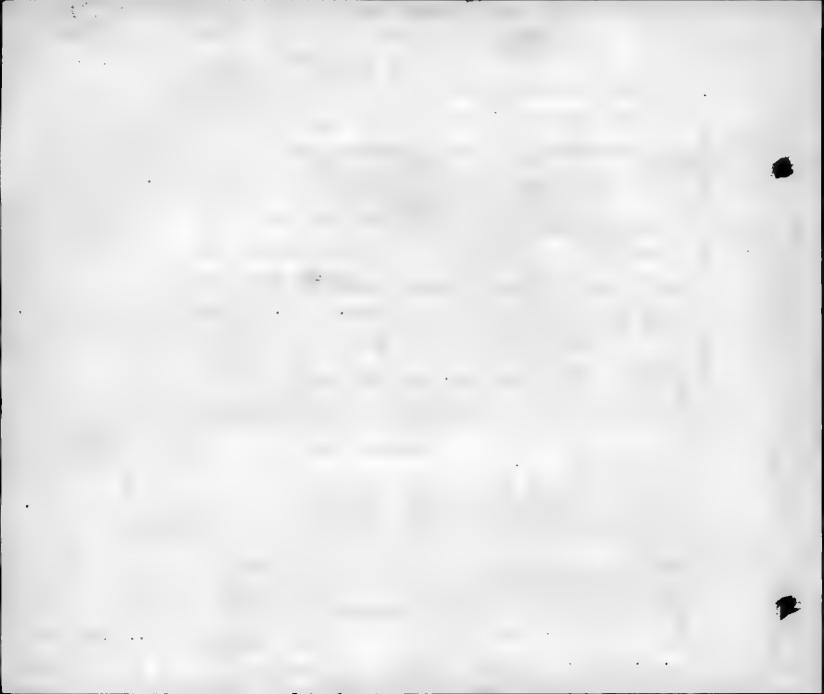


5M 9/55

arthur S. House

160

DATEMAY 5



053735327 **CERTIFICATE OF DEATH** Rea. Dist. No. director, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed **b.** COUNTY Anne Arundel MARYLAND Anne Arundel Maryland death. b. CITY OR TOWN (If outside corporate limits, write funeral c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give neorest lown Annapolis 24 days RURAL - Annapolis shavid d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE Anne Arundel General Hospital ON A FARM? R.F.D. #3 YES 🗍 NO 🗙 NAME OF Middle 4. DATE Month Doy Year DECEASED OF DEATH (Type or print) Edna WHITWORTH Mav 1960 5. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS. 7. MARRIED TO NEVER MARRIED 8. DATE OF BIRTH last birthday) 57 yrs Days Hours Female White WIDOWED [DIVORCED | March 17, 1903 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physicic 72 haurs o 0 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT attending please CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a **DUE TO** any Conditions, if ony, which lbì gave rise to immediate **DUE TO** couse (a), stating the underlying cause lost. **buriol-transit** (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO X 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (Stote) (County) factory, street, office bldg., etc.) Hour a.m. While Not while of work at work 1960, to May 3. 1960 that I last saw the deceased 21. I certify that I attended the deceased from Apr . 9. and that death occurred at 2:05P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, slote) DATE SIGNED Franklin St. SIGNATURE should PHYSICIAN'S NAME (Type) Edward S. BECK Annapolis, Maryland 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 10 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR VS A15 (4) 15M 9/55 Cirthur S. Krous DATE

within

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

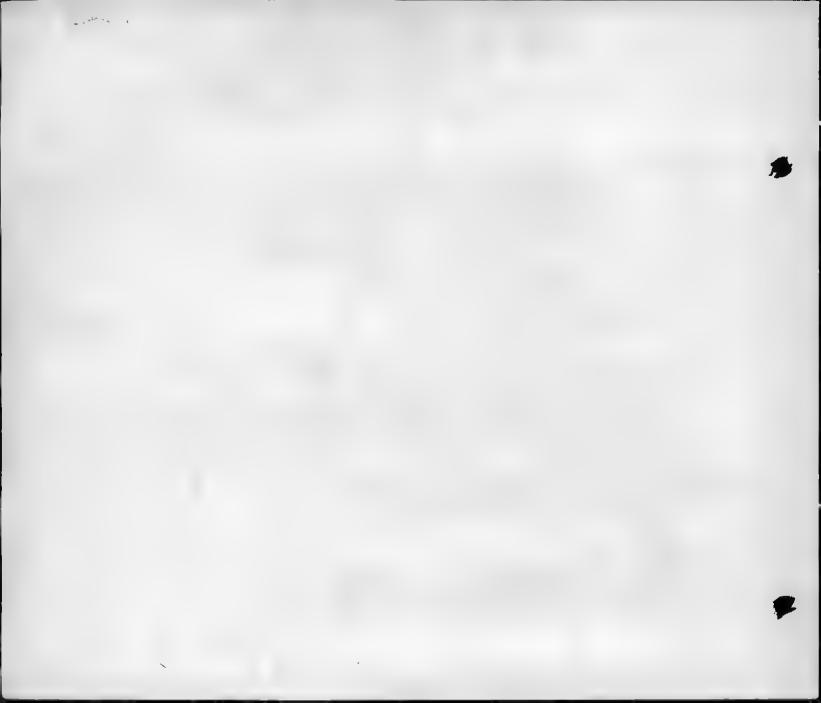
05371 CERTIFICATE OF DEATH 5385 Reg. Dist. No. director, 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. COUNTY **b** COUNTY MARYLAND funeral b. CITY OR TOWN (if autside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN UP autside corporate limits, write RURAL and give nearest town) RURAL and give hearest town) d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM YES NO NAME OF Middle Lost 4. DATE Month Doy Year DECEASED OF DEATH (Type or print) 19 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED Months Days Hours Min WIDOWED [DIVORCED [7] 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY Meign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT 22 attending please CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY Then IMMEDIATE CAUSE (o): **DUE TO** Š permit. Aup Conditions, if ony, which been signed gove rise la immediate **DUE TO** cause (a), stoting the underlying cause lost, **burial-transit** PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH 80 20c TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, 20f (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stole) factory, street, affice bldg., etc.) Hour a.m. While Not while at work at work 21. I certify that I attended the deceased from .that I last saw the deceased detached alive an and that death occurred at... M from the causes and an the date stated above. ADDRESS (Street, city or Igwn, state) DATE SIGNED ACTUAL SIGNATURE 22 shauld PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION. 22c NAME/OF CEMETERY OR CREMATORY 22d_LOCATION (City town, or country) O 23\FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b REGISTRAR'S SIGNATURE 240, REC'D BY REGISTRAR VS A15 [4] Uning S. Huma DATE MAY 3 1 °60 15M 9/55

death.

within

requires that the death certificate

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



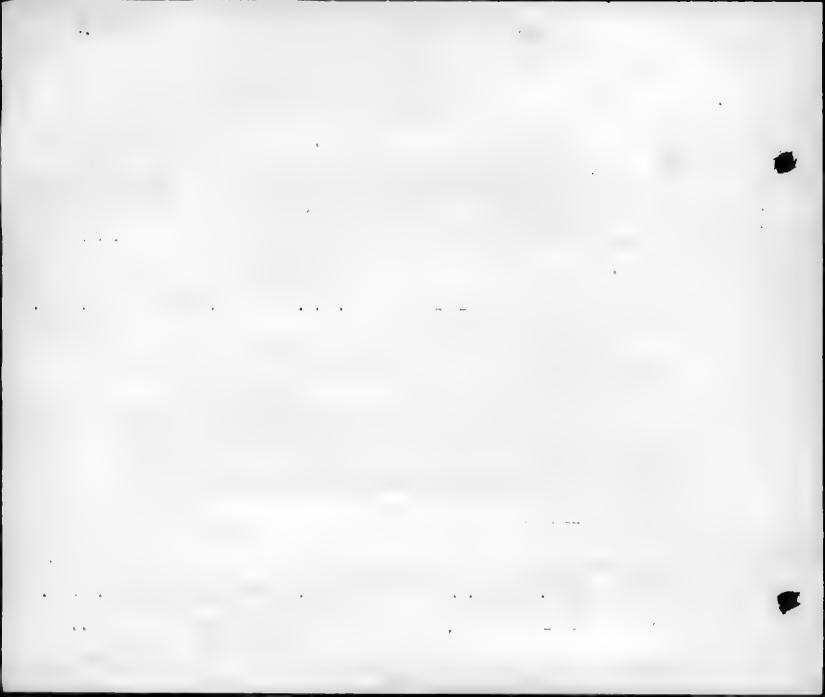
$\begin{array}{c} \text{MARYLAND STATE DEPARTMENT OF HEALTH} \\ \text{5386} & \text{CERTIFICATE OF DEATH} \end{array}$

05372

| 1. | PLACE OF DEATH o. COUNTY Anne Arundel | MARYLAN | II O. STATE 3.5 W | ere deceased lived. If institution and b COUNTY | : Residence before admission) |
|--------------------|--|-------------------------------------|---|--|--|
| | b. CITY OR TOWN (If outside corporate limits, wri RURA, and give nearest town) Glen Burnie | c. LENGTH OF STAY IN | 6. CITY OR TOWN (If o | utside corporate limits, write RUI e City | RAL and give nearest town) 3 V 11, 4 |
| 1 | d. NAME OF HOSPITAL (If not in hospitol, give studies in the studies of the studi | reet oddress) | d. STREET ADDRESS 822 N. Carr | ollton Avenue | e. IS RESIDENCE ON A FARM? YES NO |
| | NAME OF DECEASED (Type or print) Benjamin Frankl | in Watson | Last | 4. DATE Month OF DEATH May | 25 Day Year 19 60 |
| 5. | 37. 7 | MARRIED NEVER MARRIED (| | lost birthday) | FUNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min |
| 10c | USUAL OCCUPATION (Give kind of work done during most of working life, even if relired) Bank Clerk | Banking | NDUSTRY 11. BIRTHPLACE (Stole Virginia | or foreign country) | U.S.A. |
| 13. | James W. Watson | | 14. MOTHER'S MAIDEN N Sarah Hei | | |
| [Ye | WAS DECEASED EVER IN U. S. ARMED FORCES? es. no. or unknown) UNKNOWN | 16. SOCIAL SECURITY NO. 578-28-0502 | 17 INFORMANT Rev. V.T.Key | 822 N. Carrol | lton Ave.Ealto.l |
| NO | Conditions, if only, which gove rise to immediate cause (o), stoting the under: Part II. OTHER SIGNIFICANT CONDITION | | eardiovascular d | | Unknown N IN PART 1(0) 19 WAS AUTOPSY PERFORMED? |
| ICAL CERTIFICATION | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | CURRED. (Enter noture of injury in to | | YES NO (\$\frac{1}{2}\) |
| MEDIC | Hour a. m. p. m. 19 of | hile Not while work of work | factory, street, office bldg., etc. | | |
| | 21. I certify that (I) (this baspital) attacks the deceased alive an May 2 220. SIGNATUSE | | hat death occurred at 12 | ED STAFF | , 19.60., that (I) (*) last an the date stated above. 22b.DATE S GNED |
| - | 22c PHYS GAN'S NAME (Type) James M. Pai | | 22d ADDRESS 400 N. Ca: | rrollton Avenue | Balto.23, Md. |
| 23 | BUTIAL (Specify) 5-27-60 | Mt.Aubur | | Baltimore, | (State) |
| | James M. Pai | 23c NAME OF CEMETE | A.D. PHYS. 20 DI 22d ADDRESS 400 N. Ca: ERY OR CREMATORY TO Cem 250. REC' | rrollton Avenue 23d LOCATION (City, 10wn, or Baltimore, D BY REGISTRAR 25b REGIST | r county) (State) |

TO HOSPECE OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 2 — Its after death. Page 4 moy the last by the haspital or afterding physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fille. It by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, ar remaval, and in ony event, within 72 hours after death. VR A15 (4) 15M 9/59



FUR STATE HEALTH DEPT. TO D. ITY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pendi in Item 18. Give Pages 1, 2, and 3 to the Taneral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Heelth, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE I, MARYLAND 5328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05374

| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before edmission) |
|---|---|
| Anne Arundel MARYLAND | b. STATE Maryland b. COUNTY Anne Arundel |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give neerest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| Annapolis | X Severna Park |
| d. NAME OF HOSP TAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS |
| Anne Arundel General Hospital | P. O. Box 455 |
| 3. NAME OF First Middle | Lasi 4, DATE Month Day Year |
| (Type or print) CHARLENE ELIZABETH | WITSIL DEATH May 3 19 60 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X B. | DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Female White widowed DIVORCED] | lev. 26, 1945 last bridgey Months Days Hours Mn. |
| | Y 11. BIRTHPLACE (State or foreign country, 12. CITIZEN OF WHAT COUNTRY? |
| Student Jr. High | Hope, Arkansas USA |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Charles P. Witsil Jr. | Elizabeth Robinson |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. II | |
| ne no none Cha | erles P. Witsil Jr. Father: Same as # 2 |
| IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart D | isease (Malformation of |
| DUE TO | Interventricular Septum) |
| Conditions, if any, which (b) | |
| gave rise to immediata causa | |
| (a), steting the underlying cause last. | |
| PART II. OTHER S GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19, WAS AUTOPSY |
| OT I | PERFORMED? |
| 20a. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW NJURY OCCURED, (E | nter nature of injury In Part I or Part II of item 18) |
| PART II, OTHER'S GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 2Db. DESCRIBE HOW INJURY OCCURED. (E | |
| | CE OF INJURY (Home, farm, 2Df. (City or town) (County) (State) |
| Hour a.m. Whila Not Whila et work at work | ry, meat, onica biog., aic.) |
| 21. I certify that I took charge of the remains described above, hel | d an Autopsy X. Inspection , Inquiry , and in my opinion |
| death resulted from: Natural causes X. Accided , Suici | de . Homicide . Undetermined manner . |
| | CHIEF MEDICAL EXAMINER |
| SIGNATURE (C) LGI LLO S Tello | M.D. ASSISTANT MEDICAL EXAMINER TO DATE SIGNED |
| | DEPUTY MEDICAL EXAMINER 14/3/60 |
| NAME (Type) Charles S. Petty, M.D. | Addrass (Street, city, lown, or county) |
| 22a. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR REMOVAL (Specify) | |
| Birial May 7, 1960 Wilming+on&Bran | |
| | MAY 9 60 Caribus & Fusua |
| Annapolis, Merylan | nd DATE |



| MARYLAN | D STATE DEPA | RTMENT OF HEA | ALTH-BALTIMORE, 1 | 8 |
|---------|--------------|---------------|-------------------|---|
| | | | | |

CERTIFICATE OF DEATH 5329 Rea. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND Anne Arundel Maryland Anne Arundel b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Annapolis Arnold d. NAME OF HOSPITAL (If nat in haspital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? YES NO Arundel Rt. General NAME OF 4. DATE OF First Middle Lost Month Doy Year DECEASED (Type or print) Raloh DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lost birthdoy) Months Doys Hours White WIDOWED [7] DIVORCED | Male yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even it retired) 13. FATHER'S MAME 14. MOTHER'S MATDEN NAME · Unknown senown 1S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANI INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY 26 IMMEDIATE CAUSE (a) Cerebral hemorrhage with heminlegia hours left DUE TO Conditions, if any, which vpertensive arterio sclerotic heart gave rise to immediate DUE TO couse (a), stoting the underlying couse last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO

20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY I Hame, form, Month, Doy, Year 20d. INJURY OCCURRED 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. While Nat while

August. 56 ta May ____ 1960that I last saw the deceased 21. I certify that I attended the deceased fram.____ and that death accurred at 9:30 M; from the causes and an the date stated above. DATE SIGNED ADDRESS (Street, city or town, state)

(County)

(Stole)

(Stole)

ACTUAL .Box SIGNATURE

ot wark

of work |

p. m.

Codd NAME (Type) 22b. DATE THEREOF 22d. LOCATION/(City, town, arycaunty) 220. BURIAL, CREMATION, 22c. NAME OF CEMETERY OR CREMATORY

6 ADDRESS EUNERAL DIRECTOR'S SIGNATURE 24g, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DAMAY 3 1 '60 Circling S. Frank

VS A1S (4) 1SM 9/SB

Margarat Conversion Lare there there was -THE LOW SEALON ELLOSS, Look and Determination of the End. The state of the s The Hart Hall to the terminal of the terminal as it will be to the the March to the will have the material market and Blake stock that the real world in the STATE OF THE STATE

| 1 | | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 15376 5387 CERTIFICATE OF DEATH |
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| 4 22 | | 5387 CERTIFICATE OF DEATH Reg. Dist. No. |
| Page | 1. | PLACE OF DEATH o. COUNTY A.A. MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY b. COUNTY |
| deoth. | | b. CLEV OR TOWN (If ausside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If ausside corporate limits, write RURAL and give nearest lown) |
| by the d 2 shou | 4 | d. NAME OF HOSPITAL (Urrol inhospital, give street oddress) OF INSTITUTION ON A FARM? YES NO |
| illed in 24 pz | 3. | NAME OF DECEASED (Type or print) Rome Esta Houngs Death Month Day Year OF DEATH Many 25 19 60 |
| d within 2 pletely fille rs. Poges | L | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED D. DATE OF BIRMS WIDOWED DIVORCED 1/30 PM Stricthdoy Months Coys & Hours Miny |
| and cample ban papers. |) 10 | o. USUAL OCCUPATION (Give kind of work done of the line) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY OF THE LINE OF WHAT COUNTRY OF THE LINE OF WHAT COUNTRY OF THE LINE OF WHAT COUNTRY OF THE LINE OF WHAT COUNTRY OF THE LINE OF WHAT COUNTRY OF THE LINE OF TH |
| officer of the b | 113 | Stipher W. Garage allere Stories |
| ng physic remove 72 haurs | 150 | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (If yes, give wor or date of service) Address |
| if the death
the attendin
Then please
vent within | | PART I. DEATH WAS CAUSED BY: DUE TO
| equires than a signed by it permit, id in any e | | Canditions, if ony, which gave rise to immediate cause (a), stating the under- |
| the faw red physician, has been si rial-transit maval, and | CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO [W] |
| the but or rel | 1 CERTIFI | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part II of ilem 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| PHYSIC dol or of this cert r use os emotion | MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of twork of twork of twork of two two that the control of two two two two two two two two two two |
| NDING e hospit : Affer ched fo urial, cr | | 21. I certify that I attended the deceased from 196 - 196 to 5/25 that I last saw the decease alive on 5/25 that I last saw the decease alive on 5/25 M, from the causes and on the date stated above |
| R ATTER | 1 | ACTUAL CLOSE (Street, city or lewn, stote) ACTUAL SIGNATURE CLOSE (Street, city or lewn, stote) ACTUAL SIGNATURE CLOSE (Street, city or lewn, stote) ACTUAL SIGNATURE CLOSE (Street, city or lewn, stote) |
| OSPITEL OF DESTREE OF 3 SPAULE FEGISTRAL PROPERTY OF THE PROPE | | PHYSICIAN'S Charles L. Ball, M.D. Linthicum, Md. |
| may be page 3 FUNE | 22 | DEBURIAL, CREMATION, 226. DATE THEREOF 226. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stole) Burial 5/29/60 Maple Grove Shinglehouse, Pa. |
| VS A1S (4) 15M 10/57 | | FUNERAL DIRECTOR'S SIGNATURE HOpping and Kirkley, Glen Burnie Med Date MAY 31'60 Carling S. King |
| | - | |

OFFITRICATE OF DEATH and the second of the second of the second